CLEARINGHOUSE

MEDICAID AND AFDC FRAUD AND ABUSE CONTROL AND RESTITUTION EFFORTS BY STATES AND LOCALITIES

"BEST PRACTICES" CASE STUDY: WASHINGTON MEDICAID PROGRAM

December 1976

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
HEALTH CARE FINANCING ADMINISTRATION
MEDICAID BUREAU

REPORTS
RA
412
.4
M4201
1976
Medicaid
Washington

RA
412.4
.M4201
1976
Medicaid
Washington State

CLEARINGHOUSE

"Best Practices" Case Study

Washington Medicaid Program

A Descriptive Review of Exemplary
Program Options

Prepared Under SRS Contract No. SRS-500-75-0004

by

N.D. Mail

J.J. McCord

for

General Research Corporation
Westgate Research Park
McLean, Virginia 22101

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Health Care Financing Administration
Medicaid Bureau

For additional information concerning the procedures discussed in this report, contact:

Robert Nielson
Special Investigations Office
Mail Stop 343
Department of Social and Health Services
Olympia, Washington 98504

PREFACE

This report is one of a series of "best practices" case studies prepared by General Research Corporation and its subcontractor SysteMetrics under contract to the Office of Planning, Analysis and Evaluation, Social and Rehabilitation Service, Department of Health, Education and Welfare. These case studies are part of a larger effort by General Research Corporation and its subcontractor SysteMetrics to assist DHEW in the analysis of the fraud and abuse control activities nationwide in Medicaid and Aid to Families with Dependent Children programs. Other activities include a nationwide mail survey to collect baseline data on fraud and abuse control efforts in all states and an analysis of the options available to the Federal government to further enhance fraud and abuse control in these programs.

The "best practices" case studies are based on visits made by GRC/SysteMetrics staff to selected states which appeared to constitute the best examples of fraud and abuse control programs. The primary objective of this effort is to determine what procedures and practices that the selected states are using appear to be effective and worthy of replication in other jurisdictions. Each state is individually reported in this case study format and from this data base a final analytic report discussing the relative value of the exemplary practices seen in all states will be prepared. The states to be reported in this series include:

Medicaid	AFDC
California	Maryland
Maryland	Massachusetts
Massachusetts	Michigan
Michigan	Minnesota
New Jersey	New Jersey
Ohio	Ohio
Oklahoma	Pennsylvania
Pennsylvania	Washington
Washington	Wisconsin

The states were selected in conjunction with DHEW personnel and represent those states which appeared to represent a mix of practices of interest to the study and which were suitable for site visits at the time of the study. Therefore, these do not necessarily represent the "best" nine states with respect to fraud and abuse control in each program but are certainly among the best.

Fraud and abuse control is an integral part of maintaining program integrity and increasing the quality and efficiency with which the program is administered and program goals are achieved. It is essential that fraud and abuse control procedures not be viewed in isolation from other program elements, but should be recognized as being part of a series of steps which states can take to improve the operation of their programs and reduce costs incurred through the misappropriation of program funds. Therefore, in the course of conducting this study and in developing the case study reports, fraud and abuse control efforts have been defined to include all systems and procedures which impact fraud and abuse prevention, detection, investigation, administrative actions, prosecutions and recovery. The case studies are organized to report each state's activities in these functional areas in the initial chapters. The authors' opinions and analysis have been reserved for the final chapter on best practices. The best practices chapter is designed to discuss conceptually how and why procedures reported in the initial chapters are exemplary and may be suitable for replication in other jurisdictions. Therefore, the best practices chapter discusses the pros and cons of such practices in various settings and is not directly a comment on the state reported, but rather an analysis of the practice per se and how the reported state exemplifies the concept.

Finally, these reports are in no way intended to be evaluations of the states involved and General Research Corporation is deeply indebted to the states which so graciously participated and assisted in these studies through the contribution of their time, information, and ideas.

Table of Contents

Page

1 Introduction 1

2 Program Overview 3

- 2.1 History 3
- 2.2 Program Characteristics 3
- 2.3 Overview of Administration 15

3 Control of Medicaid Provider Fraud 26

- 3.1 Provention of Provider Fraud 26
- 3.2 Detection of Provider Fraud 35
- 3.3 Investigation of Provider Fraud 38
- 3.4 Disposition of Provider Fraud 45
- 3.5 Assessment of Provider Fraud Control Program 46

4 Control of Medicaid Recipient Fraud 48

- 4.1 Prevention and Detection of Recipient Fraud 48
- 4.2 Investigation and Disposition of Recipient Fraud 49

5 Control of Fraud Committed by Medicaid Agency Personnel 51

6 Best Practices for Controlling Medicaid Fraud 52

- 6.1 Best Practices for Preventing Fraud 52
- 6.2 Best Practices for Detecting Fraud 53
- 6.3 Best Practices for Fraud Investigation 53
- 6.4 Best Practices for Disposition of Fraud 54

Appendix

- List of Documents Collected
- Exhibits

List of Tables

		Page
Table I.	Health Resources in Washington 1974	9
Table II.	Department of Social and Health Services Budget 1975-77 Biennum	10
Table III.	Medical Assistance Program Budget Request, 1975-77 Biennium	12
Table IV.	Supplemental Budget Request for Medical Assistance Program, 1975-77 Biennium	14

List of Figures

		Page
Figure 1.	Distribution of Health Professionals	9
Figure 2.	DSHS Expenditures as a Percent of Total State Budget	11
Figure 3.	Washington State Government	15
Figure 4.	DSHS Organization Chart	18
Figure 5.	Health Services Division, DSHS	19
Figure 6.	Community Services Division, DSHS	20
Figure 7.	Administrative Services Division, DSHS	21
Figure 8.	Management and Budget Division, DSHS	22
Figure 9.	Planning and Research Division, DSHS	23
Figure 10.	Office of Special Investigations, DSHS	24
Figure 11.	Assistant Attorney General's Division	25
Figure 12.	Placement of Office of Operations Review within DSHS	31
Figure 13.	Organization Chart for Office of Operations Review	32
Figure 14.	Explanation of Medicaid Benefits	39
Figure 15.	OSI State Office Caseflow	42
Figure 16.	OSI Field Office Caseflow	43

SUMMARY REPORT: STATE OF WASHINGTON TITLE XIX PROGRAM

1 INTRODUCTION

This report presents the findings of a five-day visit to the State of Washington to learn how Washington controls fraud in its Title XIX (Medicaid) program. Data were gathered from structured interviews with state and local personnel and from documents obtained during the visit. The following people were interviewed:

Social and Rehabilitation Services, DHEW - Region X

- Charles M. Cruz

Department of Social and Health Services, State of Washington (Olympia)

- Office of Special Investigations
  - Bob Nielson, Director
  - Ron Crawford, Assistant Director
    - Betty Loughridge
  - Seattle Regional Office
    - John Templeton, Regional Supervisor, OSI
- Health Services Division
  - Office of Medical Assistance
    - Bob Caetano, Head, Management and Systems Section
    - Al Whitehall, Management and Systems Section
    - Wesley Brock, MD, Professional Services Section
  - Office of Nursing Home Affairs
    - Alberta Larson, Head, Professional Services Section
    - Dean Keith, Nursing Home Survey Section
- Management and Budget Division
  - Office of Operations Review
    - William Gammon, Chief
  - Office of Fair Hearings
    - Loren Keely
    - Dave Henry
- Planning and Research Division
  - Office of Program Analysis
    - Hugh Funk, Head, Quality Control Section

Administrative Services Division

  Office of Staff Services

    Robert Manley, Supervisor, Contracts and Reimbursements Section

Community Services Division

  Bureau of Social Services

    Income Maintenance Section

      Pat Hague, Field Unit

    Pacific ESSO Regional Office

      Diane Exeriede, RFIS Supervisor

Assistant Attorney General's Division

  Regional Office (Seattle)

    Ken Shiraga, Deputy Prosecutor, "White Collar Crime" Unit
    Fred Mendoza, Deputy Prosecutor

2 PROGRAM OVERVIEW

2.1 HISTORY

Washington's Medicaid program went into operation on July 1, 1966, two days after the State Plan was approved. From the beginning medical coverage was extended not only to public assistance recipients, but to the medically needy as well. This coverage originally began in 1955, when Washington enacted a statute that provided for "needed medical, dental and allied services to recipients of public assistance and medical indigents". Washington thus became one of the first states to offer these services to people meeting all public assistance eligibility criteria except income level, but whose income was nevertheless insufficient to meet the costs of necessary medical care.*

2.2 PROGRAM CHARACTERISTICS

The Department of Social and Health Services (DSHS) is the single state agency for the Title XIX, medically needy and state-funded Medical Only (MO) programs. All claims processing except for dental services is done for DSHS by Electronic Data Systems (EDS-Federal) of San Francisco. Washington Dental Services has been fiscal intermediary for dental services, though dental claims processing is now being switched to EDS for DSHS.

Medical assistance is available for

TITLE XIX

1) persons receiving continuing federally-assisted public assistance cash grants (AFDC, OAA, APTD, AB) or SSI);
2) certain children under 21;
3) Medicare-eligibles whose benefits have been exhausted

---

* In October 1960 Washington was able to implement the Medical Assistance for the Aged (MAA) program under existing statute, although further legislation related specifically to MMA was enacted in 1963.

TITLE XIX Medically Needy

4) categorical-eligibles whose income and/or resources exceed standards but are insufficient to meet the costs of necessary medical care;

5) non-categorically-related recipients of continuing general assistance cash grants;

State-Funded Medical Only

6) recipients of non-continuing general assistance cash grants;

7) medical indigents*

To be eligible for medical assistance, a person must be a current or intended resident of Washington. While there is no length-of-stay requirement, medical assistance is not meant for those who go to Washington solely for the purpose of obtaining medical care.

MO eligibility is limited to persons with "acute and emergent needs." An acute condition is defined as "having a short and relatively severe course, not chronic"; an "emergent condition" is defined as "occurring unexpectedly and demanding immediate action." Included in these definitions are "conditions of less urgency where medical experience indicates a failure to treat will usually result in the rapid development of an emergent situation." An acute and emergent condition is also assumed to exist "when an applicant for medical care indicates he has an undefined medical condition."**

In addition to program eligibility requirements, applicants for medical assistance must meet the following financial criteria:

A. Categorically-eligible persons, including those receiving aid and those who, though eligible, choose not to receive aid:

- Income and resources consistent with the program for which eligible

B. Medically needy persons:

- Income not to exceed $370 per month for a 4-person family. Additional $55 per month for each additional family member

---

* Medical indigents generally are persons between the age of 21 and 65 years of age who are neither blind nor disabled as legally defined, but whose income, credit, potential earnings or medical resources are insufficient to meet the costs of necessary medical care.

** Washington Administrative Code, Title 388-86-120, Amended 4-13-75.

- Resources:

	Cash and Marketable Securities	Total of Cash, securities, car equity, and cash value of insurance
1-person family	$200	$ 750
2-person family	$400	$1450
each additional person	$ 25	$ 50

C. Medical Only persons:

- Same as medically needy. In addition, an annual deductible of $100 per family must be satisfied.*

A home, used and useful household furnishings and personal clothing, articles of sentimental value, and livestock owned by children for the purpose of participating in 4-H or school activities are exempt from consideration as resources. While having resources in excess of standards does not automatically deny eligibility, payment for medical assistance is reduced by the dollar amount of the excess.

The scope of benefits is identical for both the Title XIX and medically needy programs, with one exception: temporary out-of-state care is covered for Title XIX, but not for medically needy. "Bordering state"** situations are not considered out-of-state for either program. Benefits include:

---

* The first time a recipient of non-continuing general assistance or medical only coverage applies for medical payment, he must demonstrate that $100 in medical costs have been incurred within seven days prior to application. Failing this, his application for payment is denied. He then has twelve months from the date of first application to incur $100 in medical costs. This provision in the Washington Administrative Code (WAC 388-87-025) gives rise to the following situation: when an application for medical payment that is subject to the $100 deductible is received, the deductible is "assigned" to one provider. Payment by DSHS to that provider can be made only after $100 in medical costs have been incurred and paid by the applicant. Other providers serving the same applicant may be paid by DSHS at anytime.

** A "bordering state" is one whose trade area is within 15 miles of Washington.

1. Hospital services, both inpatient and outpatient (subject to prior authorization and LOS limitations. Except for emergencies, no hospital admission may take place on Friday or Saturday).
2. Laboratory and X-ray services.
3. Skilled nursing home care.
4. Physician's services in the home, office, nursing home, hospital, extended care facility, or elsewhere; these include administration of anesthesia, diagnostic X-rays and therapy, and surgery. (Non-emergency surgery requires prior authorization).
5. Home health services.
6. Special duty nursing services (prior authorization required).
7. Dental care (with limitations; prior authorization required).
8. Physical and speech therapy (prior authorization required).
9. Chiropractic care (with limitations).
10. Hearing aids (with limitations).
11. Prescription drugs (formulary).
12. Eye examinations and glasses (prior authorization required).
13. Crutches, wheel chairs, braces, artificial limbs, etc., when approved.
14. Patient transportation (ambulance and other; prior authorization required for all but ambulance).
15. Oxygen in a patient's home or nursing home (prior authorization required for those under 65).
16. Medical social services.
17. Family planning.
18. Early and periodic screening (ages 0 to 21).
19. Outpatient mental health services (with limitations. Inpatient mental health services limited to those over 65).
20. Kidney treatment, transplants, dialysis, equipment and supplies.
21. Alcoholic detoxification (with limitations).
22. Deductible and coinsurance for Title XVIII.
23. Funeral expenses (with limitations).

Title XVIII benefits must be used before making a Title XIX claim.

MO benefits are authorized for treatment of acute and emergent conditions only except as specified below. Once treatment has begun, it is identical in amount, duration, and scope to the regular medical assistance program. Exceptions to "acute and emergent" restrictions include:

- certain drugs necessary to treat cardiovascular, diabetic, epileptic, nephritic, and cancerous conditions;
- drugs for former mental patients and for students in schools for the mentally retarded;
- innoculation to prevent rabies;
- dental care to relieve pain or surgically repair the jaw;
- maternity care for non-residents if such care is not covered by the state-of-residence.

Prior authorization is required for all MO services, including outpatient and emergency care, home health services, and drugs not mentioned above. Transportation costs will only be paid after the $100 deductible has been satisfied. No out-of-state care is covered except in "bordering state" situations.

Eligibility for federally-assisted medical programs is retroactive three months provided the recipient was eligible when care was given. Such an applicant need not be eligible for medical assistance at the time of application. For state-funded medical assistance, eligibility is retroactive 7 days prior to the date of application, provided all conditions of eligibility could have been satisfied then. Eligibility on applications submitted more than 7 days after medical services began is not retroactive, but begins with the date of application.

Instead of fee-for-service medical coverage, certain families may voluntarily elect prepaid coverage by Group Health Cooperative of Puget Sound. Monthly premiums are paid by DSHS.

In FY 75, approximately 245,392 persons per month were covered by Title XIX. State-financed medical assistance was extended to an average of 9,262 persons per month.*

---

* Source: Annual Report 1975, Human Resources Agencies, State of Washington, p. 80.

Providers eligible to participate in Washington's medical assistance programs include:

1) all physicians, chiropractors, osteopaths, dentists, optometrists and podiatrists currently licensed by the state;
2) all professional and practical nurses and physical therapists currently licensed by the state;
3) hospitals, nursing homes, and extended care facilities licensed and classified by DSHS;
4) licensed pharmacies;
5) DSHS-certified home health services agencies;
6) certain suppliers of ancillary services such as ambulance, oxygen, eyeglasses, prostheses, etc.
7) certified alcohol detoxification centers.

Specifically excluded as providers are unlicensed practitioners, Christian Science and other theological practitioners, masseurs, and others (herbalists, homopathists, naturopaths, sanipractors).

Providers must have an appropriate "Services Agreement" on file with DSHS in order to be paid. Payment is made according to established rate schedules: RVS for physicians and other practitioners; Red Book and Blue Book or retailer cost plus dispensing fee for pharmacies; rate schedule for medical vendors; cost-reimbursement-established per diem rate for institutions. Rates for all providers were increased on July 1, 1976.

Table I lists the total number of health professionals and facilities in Washington; Figure 1 shows their distribution throughout the state.

Table I.*
Health Resources in Washington 1974

LICENSED HEALTH PROFESSIONALS

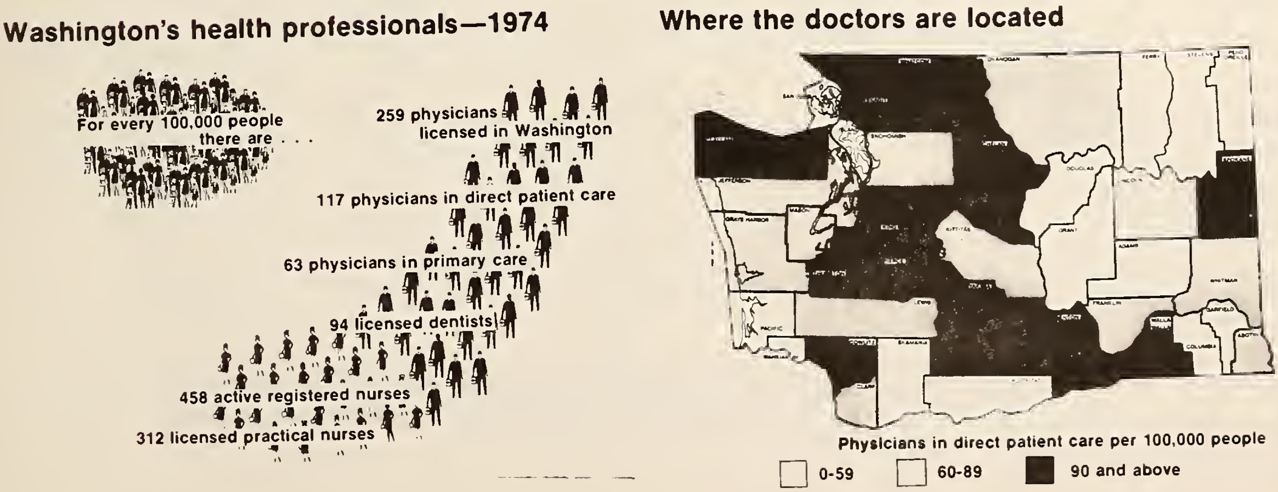
MEDICAL DOCTORS	9,447	REGISTERED NURSES	27,633
CHIROPRACTORS	578	PRACTICAL NURSES	13,064
OSTEOPATHS	425	PHYSICAL THERAPISTS	827
DENTISTS	3,333	DENTAL HYGIENISTS	1,185
PHARMACISTS	3,949	OPTOMETRISTS	746
PODIATRISTS	127	PHARMACY INTERNS	543
PSYCHOLOGISTS	413	PHYSICIANS ASSISTANTS	99
DRUGLESS THERAPEUTICIANS	72		

LICENSED FACILITIES

	NUMBER	BEDS
GENERAL HOSPITALS	114	13,173
PSYCHIATRIC HOSPITALS	5	217
NURSING HOMES	312	27,058

NOTE: STATE AND FEDERALLY OPERATED FACILITIES ARE NOT INCLUDED IN THE ABOVE

Figure 1.**
Distribution of Health Professionals


Washington's health professionals—1974

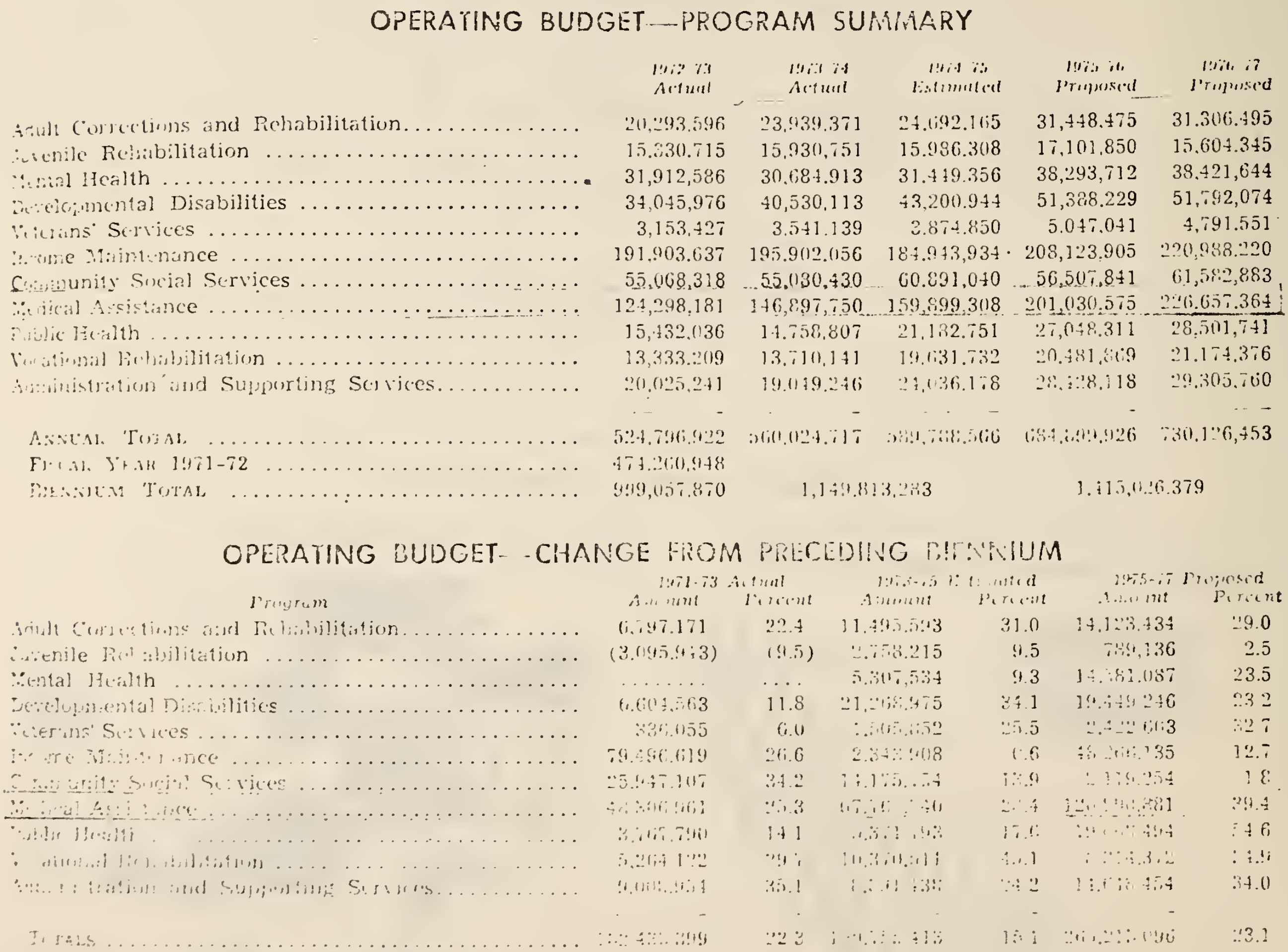
Where the doctors are located

For every 100,000 people there are . . .
259 physicians licensed in Washington
117 physicians in direct patient care
63 physicians in primary care
94 licensed dentists
458 active registered nurses
312 licensed practical nurses
OKANOGAN
FERRY
STEVENS
SNOHOMISH
JEFFERSON
GRAYS HARBOR
MASON
KITTITAS
DOUGLAS
LINCOLN
GRANT
ADAMS
WHITMAN
FRANKLIN
GARFIELD
COLUMBIA
ASOTIN
LEWIS
PACIFIC
SKAMANIA
CLARK
Physicians in direct patient care per 100,000 people
☐ 0-59
☐ 60-89
■ 90 and above

*Source: State of Washington Pocket Data Book 1975, Office of Program Planning and Fiscal Management, p. 75.
**Source: Washington State, Fall 1975, P. 18.

Funding for medical assistance programs comes from biennial legislative appropriations. If funds are exhausted prior to the end of the biennium, a request for supplemental funds may be submitted. Table II below shows the DSHS budget request for the 1975-77 biennium. Figure 2 shows this request in relation to total state budget.

Table II.
Department of Social and Health Services
Budget 1975-77 Biennium*



OPERATING BUDGET—PROGRAM SUMMARY

	1972-73 Actual	1973-74 Actual	1974-75 Estimated	1975-76 Proposed	1976-77 Proposed
Adult Corrections and Rehabilitation	20,293,596	23,939,371	24,692,165	31,448,475	31,306,495
Juvenile Rehabilitation	15,330,715	15,930,751	15,986,308	17,101,850	15,604,345
Mental Health	31,912,586	30,684,913	31,449,356	38,293,712	38,421,644
Developmental Disabilities	34,045,976	40,530,113	43,200,944	51,388,229	51,792,074
Veterans' Services	3,153,427	3,541,139	3,874,850	5,047,041	4,791,551
Income Maintenance	191,903,637	195,902,056	184,943,934	208,123,905	220,988,220
Community Social Services	55,068,318	55,030,430	60,891,040	56,507,841	61,582,883
Medical Assistance	124,298,181	146,897,750	159,899,308	201,030,575	226,657,364
Public Health	15,432,036	14,758,807	21,182,751	27,048,311	28,501,741
Vocational Rehabilitation	13,333,209	13,710,141	19,631,732	20,481,869	21,174,376
Administration and Supporting Services	20,025,241	19,049,246	24,036,178	28,428,118	29,305,760
ANNUAL TOTAL	524,796,922	560,024,717	589,788,566	684,899,926	730,126,453
FISCAL YEAR 1971-72	474,260,948				
BIENNIUM TOTAL	999,057,870	1,149,813,283		1,415,026,379	

OPERATING BUDGET—CHANGE FROM PRECEDING BIENNIUM

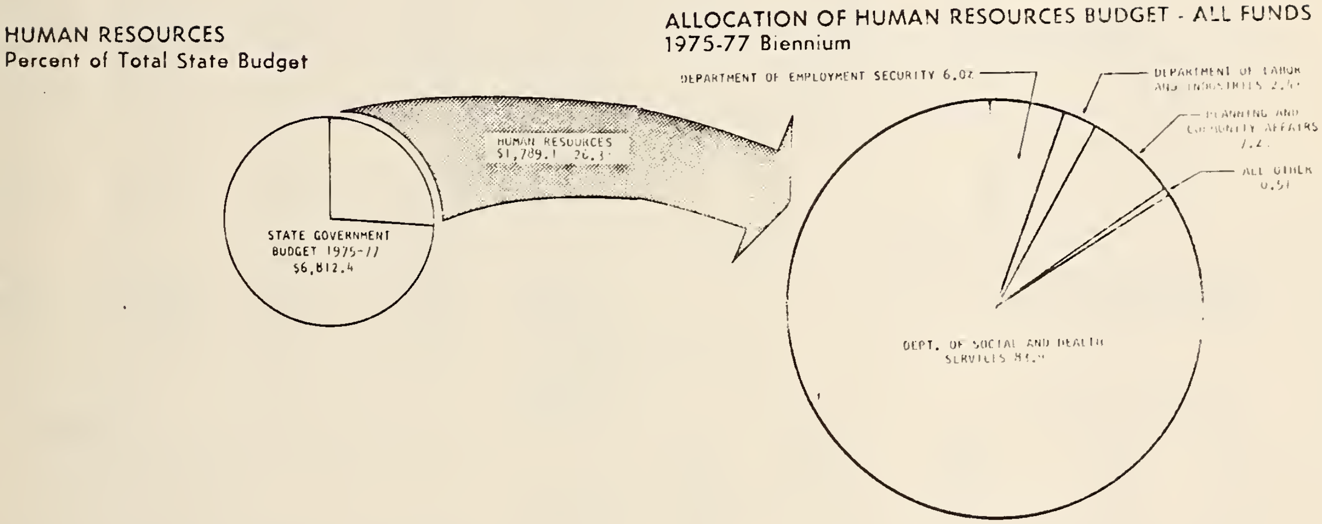
	1971-73 Actual		1973-75 Estimated		1975-77 Proposed	
Program	Amount	Percent	Amount	Percent	Amount	Percent
Adult Corrections and Rehabilitation	6,797,171	22.4	11,495,593	31.0	14,123,434	29.0
Juvenile Rehabilitation	(3,095,943)	(9.5)	2,758,215	9.5	789,136	2.5
Mental Health	....	....	5,307,534	9.3	14,581,087	23.5
Developmental Disabilities	6,604,563	11.8	21,268,975	34.1	19,449,246	23.2
Veterans' Services	336,055	6.0	1,505,652	25.5	2,422,603	32.7
Income Maintenance	79,496,619	26.6	2,343,908	0.6	48,266,135	12.7
Community Social Services	25,947,107	34.2	14,175,[illegible]54	13.9	2,169,254	1.8
Medical Assistance	4[illegible],806,961	25.3	67,[illegible]40	2[illegible].4	120,890,881	39.4
Public Health	3,767,790	14.1	5,37[illegible]93	17.6	19,608,494	54.6
Vocational Rehabilitation	5,264,122	29.7	10,370,011	45.1	8,314,372	24.9
Administration and Supporting Services	9,068,954	35.1	[illegible]38	24.2	14,648,454	34.0
TOTALS	182,433,399	22.3	150,755,413	15.1	265,213,096	23.1

---

* Source: State of Washington Budget, 1975-77, Biennium, submitted December 1974, p. 255.

Figure 2.*

DSHS Expenditures as a Percent of Total State Budget



---

* Source: State of Washington Pocket Data Book 1975, Office of Program Planning and Fiscal Management, p. 53.

A detailed breakdown of the 1975-77 budget request for the medical assistance program is shown in Table III below. Note that staffing levels are included.

Table III.*
Medical Assistance Program
Budget Request, 1975-77 Biennium

Operating Budget: Summary by Category of Assistance

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Proposed*	*1976-77 Proposed*
General Medical Assistance	118,897,953	140,649,110	152,559,445	190,202,466	215,232,986
Nursing Homes	35,562,403	43,165,302	49,942,512	56,475,537	60,917,114
Involuntary Mental Health Treatment	....	....	....	2,680,000	2,680,000
Alcoholism Treatment (Detoxification)	....	....	....	3,134,500	3,134,500
Other Medical					
Hospitals	38,346,835	43,672,214	47,015,037	54,625,810	62,018,145
Physicians	20,250,598	25,057,640	26,635,360	33,936,147	40,544,637
County Infirmaries	958,731	1,042,575	846,672	1,026,649	1,095,475
Drugs	8,367,362	10,922,882	10,297,324	13,817,899	15,822,317
Dental	7,023,708	9,402,789	10,557,706	14,589,941	17,650,304
Supplemental Medical Insurance Premiums	1,874,303	2,655,661	2,568,710	3,368,797	3,748,207
Mental Institutions	2,902,805	....	....	....	....
Health Maintenance	798,163	822,714	737,523	937,788	1,049,366
Blood, Ambulance, etc.	2,813,045	3,671,522	3,722,290	4,889,525	5,798,826
Early Screening and Diagnosis	....	235,811	236,311	719,873	774,095
Prevention of Blindness Assistance	585,927	484,546	1,164,464	884,371	944,984
Eligibility Determination	2,268,456	2,592,245	2,853,010	2,627,127	2,690,835
Program Support	2,545,845	3,171,849	3,322,389	7,316,611	7,788,559
ANNUAL TOTAL	124,298,181	146,897,750	159,899,308	201,030,575	226,657,364
FISCAL YEAR 1971-72	114,733,037				
BIENNIUM TOTAL	239,031,218	306,797,058		427,687,939	

Source of Funds

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Proposed*	*1976-77 Proposed*
General Fund—State	61,467,727	74,939,914	82,508,007	99,628,338	112,188,990
General Fund—Federal	59,045,681	71,258,602	76,243,940	101,402,237	114,468,374
General Fund—Federal—Unanticipated	....	699,234	1,147,361	....	....
Contingent Receipts Fund—Federal—Unanticipated	3,784,773	....	....	....	....
ANNUAL TOTAL	124,298,181	146,897,750	159,899,308	201,030,575	226,657,364

Workload Indicators

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Estimated*	*1976-77 Estimated*
Medicaid Payments—Grant Recipients					
Average Monthly Persons	217,083	212,975	193,237	225,963	231,929
Average Cost	$39.47	$46.39	$54.29	$55.38	$60.03
Medicaid Payments—Non-grant Recipients					
Average Monthly Persons	11,059	15,393	16,560	27,965	22,615
Average Cost	$79.33	$77.66	$96.05	$78.18	$84.93
State Only Payments					
Average Monthly Persons	2,920	5,344	8,018	9,074	10,136
Average Cost	$158.00	$140.51	$78.76	$73.36	$74.85
Cuban Refugees					
Average Monthly Persons	9	10	8	8	7
Average Cost	$57.65	$3.30	$42.95	$44.86	$49.44
Total—Average Monthly Persons[a]	231,071	233,722	217,823	263,010	264,687
Total—Average Cost	$42.88	$50.15	$58.37	$60.26	$68.36

Persons based on available funds and projected average costs.
Excludes prevention of blindness.

* Source: State of Washington Budget 1975-77 Biennium, submitted December, 1974, pp. 314-318.

Operating Budget: Summary by Category of Expenditure

	1972-73 Actual	1973-74 Actual	1974-75 Estimated	1975-76 Estimated	1976-77 Estimated
Salaries and Wages	3,841,460	4,321,954	4,661,494	4.985,940	5.087.267
Personal Service Contracts	3,410	25,393	6,747	2,398,306	3,043,306
Goods and Services	496,368	663,440	669,572	1,307,724	1,371.406
Travel	62.198	60,693	76,701	128,511	127,200
Equipment	24.987	19,332	19,472	111,030	9.846
Employee Benefits	417,782	710.685	779,292	1,051,165	880,035
Contributions, Grants, Subsidies	119,451,976	141,096,253	153,686.030	191.047.899	216,138,304
ANNUAL TOTAL	124,298,181	146,897,750	159,899,308	201,030,575	226,657,364

Staffing Levels

	1972-73 Actual	1973-74 Actual	1974-75 Estimated	1975-76 Estimated	1976-77 Estimated
Local Office					
Medical Eligibility Worker	228.8	235.1	237.2	209.5	209.1
1st Line Supervisors	25.1	25.8	27.2	25.5	25.4
2nd Line Supervisors	4.8	5.9	6.0	6.2	6.2
Clerical Supervisors	8.2	8.2	8.7	15.2	15.2
Clerical	80.9	100.2	96.4	112.0	111.4
Administrators and Assistant Administrators	5.9	6.8	6.6	7.6	7.6
Workload Standards Specialists and Supporting Clerical	....	....	....	3.1	3.1
Custodial	1.0	1.4	1.8	1.9	1.9
TOTAL LOCAL OFFICE	354.7	383.4	383.9	381.0	379.9
State Office	80.9	81.8	82.9	114.3	114.3
PROGRAM TOTAL	435.6	465.2	466.8	495.3	494.2
Average FTE Staff Year Costs	8,818	9,290	9,986	10,066	10,293

Further detail (staffing level, expenditure by category, and source of funds) is available for each component in the operating budget (general medical assistance, prevention of blindness assistance, eligibility determination, and program support). See Exhibits A, B, C, D, The budget request for the 1975-55 biennium originally totaled $427,687,939, an increase of $120,890,881 (39.4%) over the preceeding biennium. The increase was requested in order to raise vendor rates. However, in January, 1976 an additional increase was requested in the Supplemental Budget, as shown in Table IV, as a result of increased caseload and need for vendor rate increase.

TABLE IV*

Supplemental Budget Request
for Medical Assistance Program,
1975-77 Biennium

Expenditure Detail

	1975-77 Appropriation	Supplemental Request	1975-77 Proposed
Salaries and Wages	11,097,233	0	11,097,233
Personal Service Contracts	5,712,896	0	5,712,896
Goods and Services	2,336,561	0	2,336,561
Travel	219,051	0	219,051
Equipment	58,407	0	58,407
Employee Benefits	2,032,137	0	2,032,137
Grants and Subsidies	397,622,162	7,700,000	405,322,162
Contingency	20,469,718*	0	20,469,718
Total	439,548,165	7,700,000	447,248,165

*Includes contingency funds from Washington Laws, 1975 1st Extraordinary Session, Chapter 269, New Section 62, subsection (8).

Source of Funds

	1975-77 Appropriation	Supplemental Request	1975-77 Proposed
General Fund - State	218,894,593	3,960,000	222,854,593
General Fund - Federal	220,653,572	3,740,000	224,393,572
Total	439,548,165	7,700,000	447,248,165

For the 1975-77 biennium, the federal matching percentage was increased to 53.72% from 53.13% for the 1973-75 biennium.

---

* Source: State of Washington Supplemental Budget 1975-77 Biennium, submitted January 1976, p. 47.

2.3 OVERVIEW OF ADMINISTRATION

To understand how Washington administers its Title XIX, medically needy, and MO programs, it is useful to examine DSHS's entire organizational structure and to see how DSHS fits into state government. Figure 3 shows DSHS within the state organization.

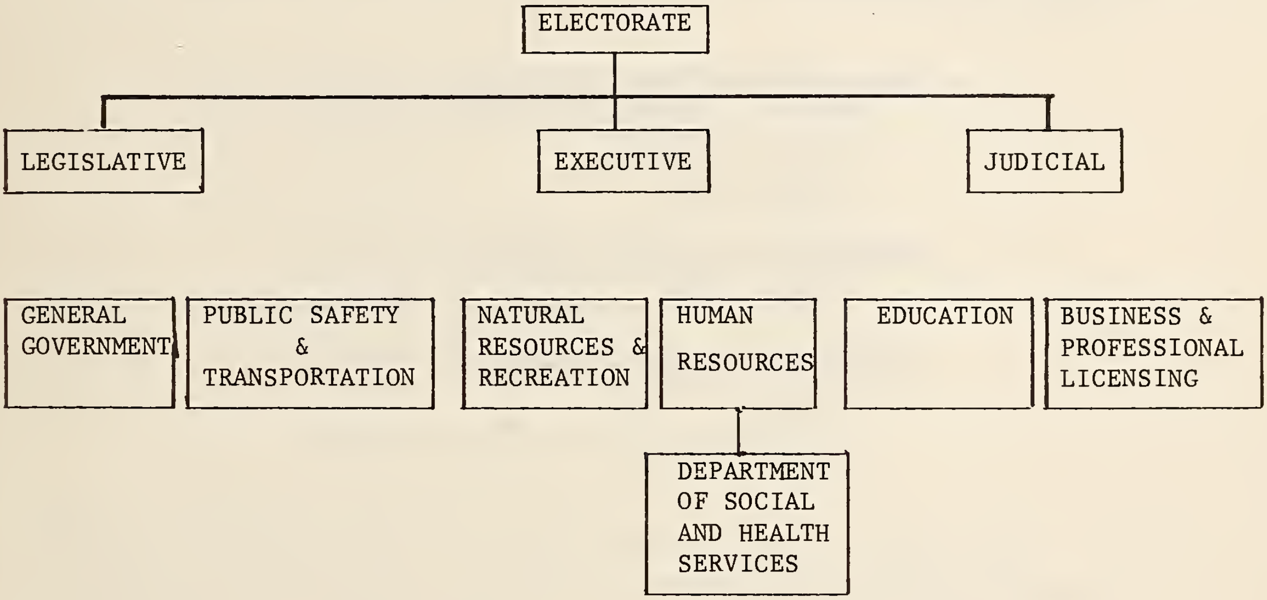

ELECTORATE
LEGISLATIVE
EXECUTIVE
JUDICIAL
GENERAL GOVERNMENT
PUBLIC SAFETY & TRANSPORTATION
NATURAL RESOURCES & RECREATION
HUMAN RESOURCES
EDUCATION
BUSINESS & PROFESSIONAL LICENSING
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Figure 3

Washington State Government*

DSHS itself is divided into four operations divisions, four staff support divisions, and five offices that report directly to the Secretary of DSHS. (See Figure 4.) The operations divisions are responsible for designing and administering programs within their jurisdiction. The medical assistance program is the joint responsibility of the Health Services Division** (benefit determination, claims processing, other program administration) and the Community Services Division, Bureau of Social Services (eligibility determination). See Figures 5 and 6.

---

* Source: Washington State Government Organization, July 1974.

** Health Services Division is also responsible for health facilities planning and resource development, community health services, and environmental health programs.

Staff support divisions serve all DSHS operations divisions, providing management assistance and program support activities that cut across various operations divisions.* Support for the medical assistance program is given by:

- Administrative Services Division (Figure 7):
    - Office of Support Enforcement (medical third party liability)
    - Office of Staff Services (contracts and reimbursements)
- Management and Budget Division (Figure 8):
    - Office of Operations Review (performance audit, cost reimbursement, fair hearings)
- Planning and Research Division (Figure 9):
    - Office of Program Analysis (internal quality control)
    - Office of Vendor Rates and Standards

The Office of Special Investigations (Figure 10) serves all DSHS, providing investigative services as needed. The majority of its work is for the Health Services and Community Services Divisions, investigating charges of provider and recipient fraud. It also investigates allegations of DSHS employee financial misconduct. Because its work is sensitive, this office is directly responsible to the Secretary of DSHS.

Most fraud cases involve violations of both state and federal laws, resulting in dual legal jurisdiction. DSHS resolves this by referring fraud cases to the county prosecutor first. If the county prosecutor fails to file charges the case may then be referred to the US Attorney for prosecution.

---

* Detailed budget information (operating budgets by nature of expenditure and category of labor, staffing levels, and source of funds) for support divisions is given in Exhibit E.

Finally, the legal unit should be mentioned. Though strictly speaking it is not a part of DSHS, there is an Assistant Attorney General's Division (Figure 11) assigned to DSHS. It provides counsel for all Department divisions and offices. In addition its Seattle Regional Office contains a new "White Collar Crime" unit that has an interest in provider fraud.

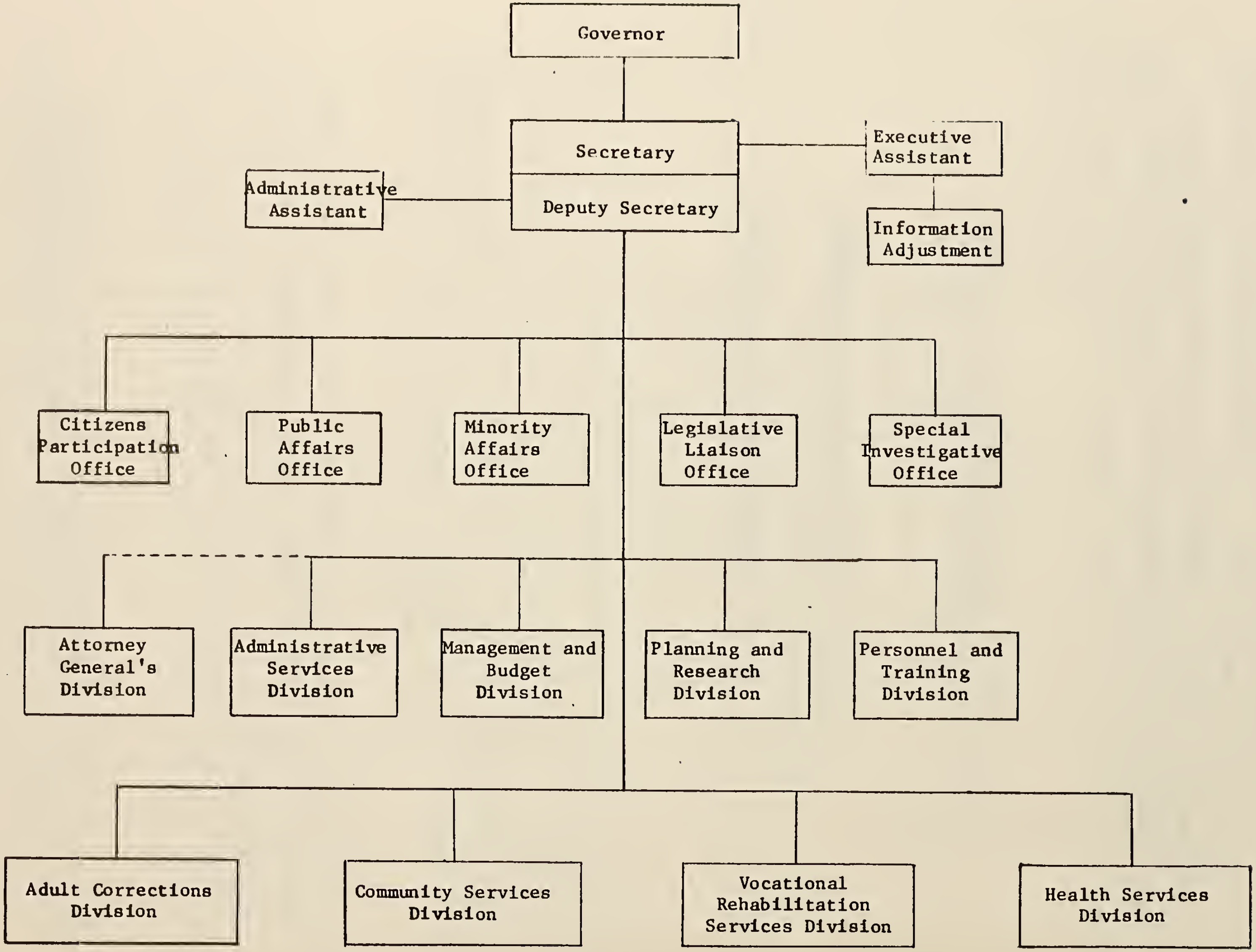

Governor
Secretary
Deputy Secretary
Administrative Assistant
Executive Assistant
Information Adjustment
Citizens Participation Office
Public Affairs Office
Minority Affairs Office
Legislative Liaison Office
Special Investigative Office
Attorney General's Division
Administrative Services Division
Management and Budget Division
Planning and Research Division
Personnel and Training Division
Adult Corrections Division
Community Services Division
Vocational Rehabilitation Services Division
Health Services Division

Figure 4

DSHS Organization Chart

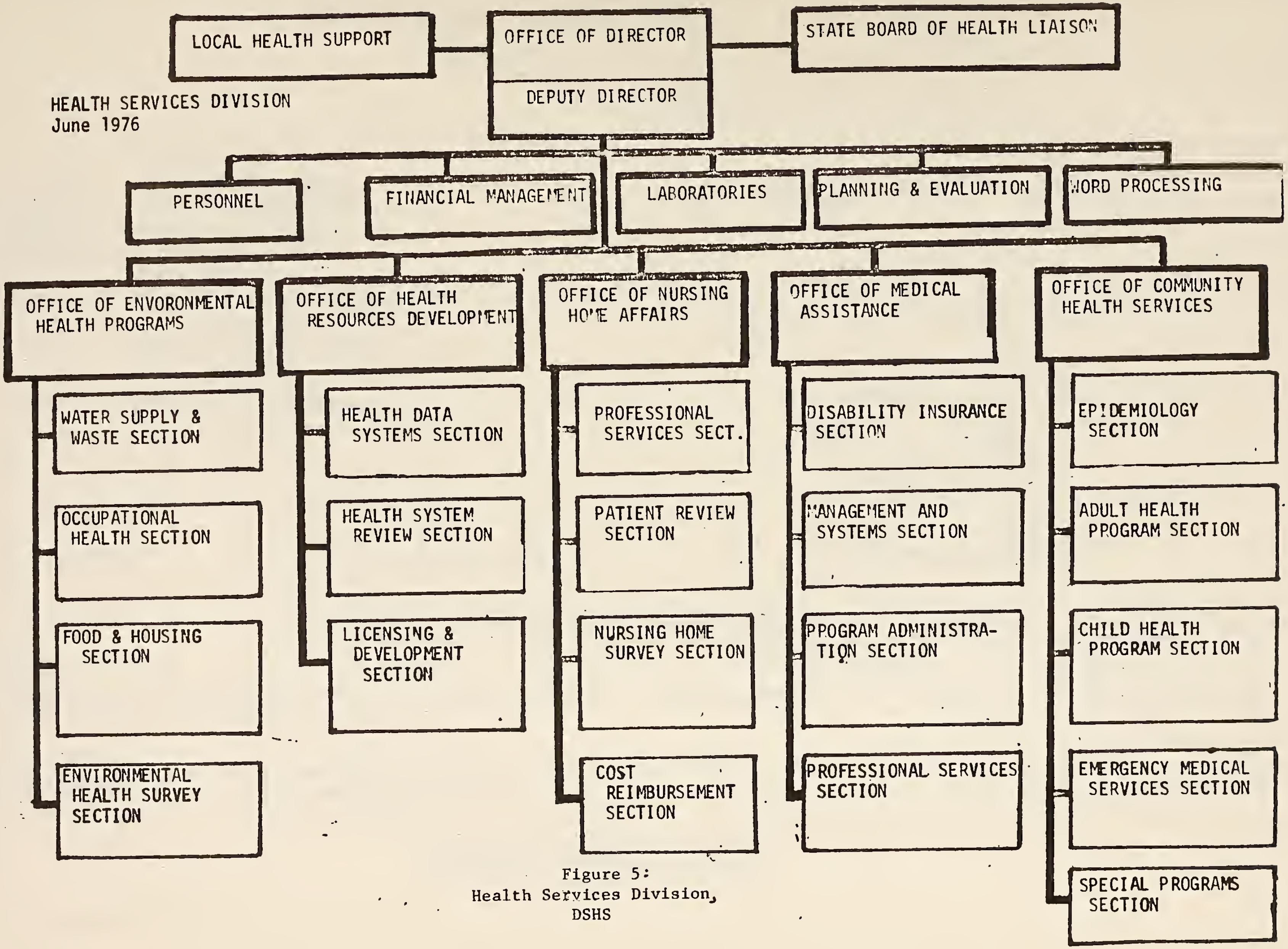
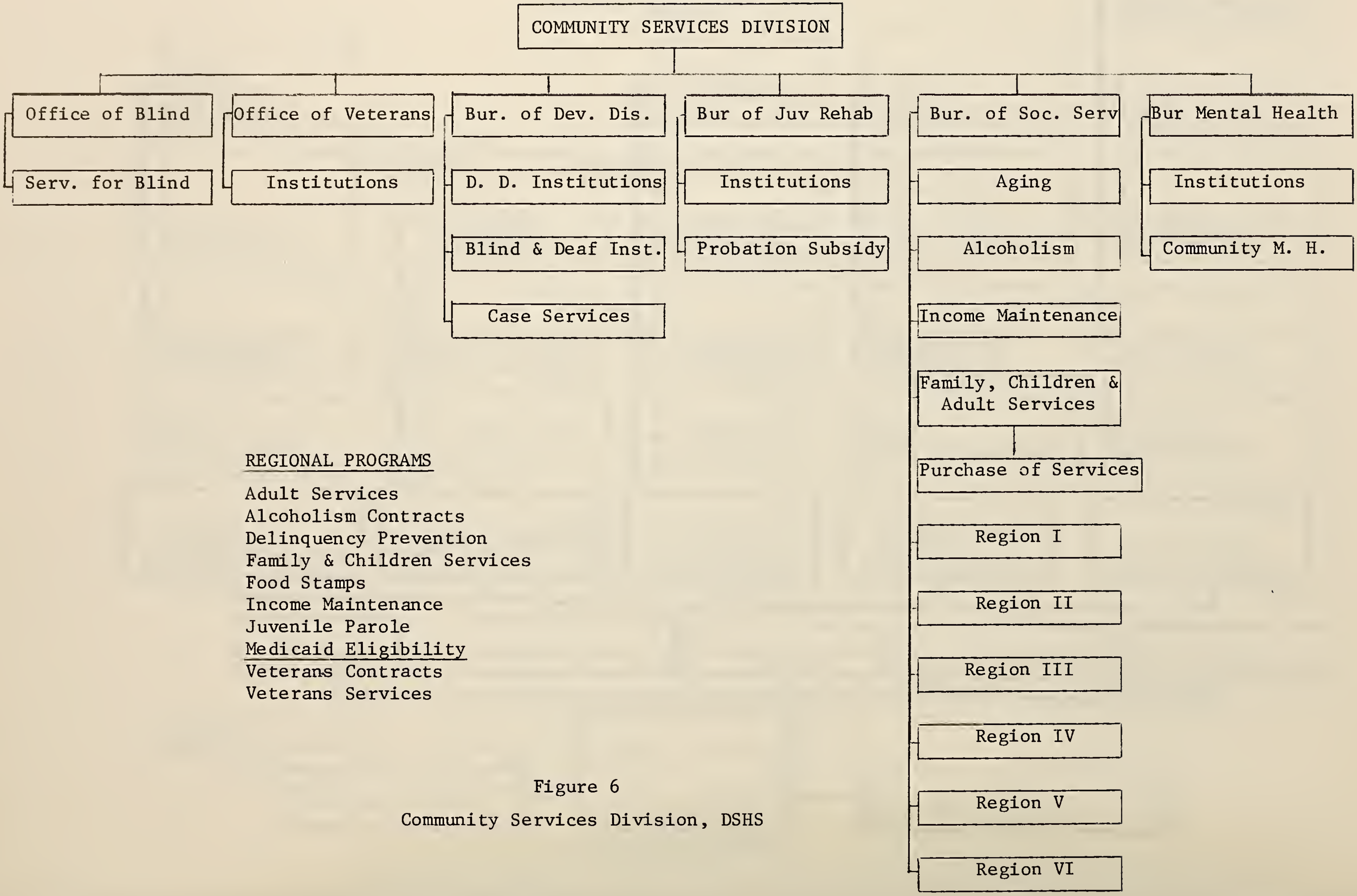

LOCAL HEALTH SUPPORT
OFFICE OF DIRECTOR
DEPUTY DIRECTOR
STATE BOARD OF HEALTH LIAISON
HEALTH SERVICES DIVISION
June 1976
PERSONNEL
FINANCIAL MANAGEMENT
LABORATORIES
PLANNING & EVALUATION
WORD PROCESSING
OFFICE OF ENVORONMENTAL HEALTH PROGRAMS
WATER SUPPLY & WASTE SECTION
OCCUPATIONAL HEALTH SECTION
FOOD & HOUSING SECTION
ENVIRONMENTAL HEALTH SURVEY SECTION
OFFICE OF HEALTH RESOURCES DEVELOPMENT
HEALTH DATA SYSTEMS SECTION
HEALTH SYSTEM REVIEW SECTION
LICENSING & DEVELOPMENT SECTION
OFFICE OF NURSING HOME AFFAIRS
PROFESSIONAL SERVICES SECT.
PATIENT REVIEW SECTION
NURSING HOME SURVEY SECTION
COST REIMBURSEMENT SECTION
OFFICE OF MEDICAL ASSISTANCE
DISABILITY INSURANCE SECTION
MANAGEMENT AND SYSTEMS SECTION
PROGRAM ADMINISTRATION SECTION
PROFESSIONAL SERVICES SECTION
OFFICE OF COMMUNITY HEALTH SERVICES
EPIDEMIOLOGY SECTION
ADULT HEALTH PROGRAM SECTION
CHILD HEALTH PROGRAM SECTION
EMERGENCY MEDICAL SERVICES SECTION
SPECIAL PROGRAMS SECTION

Figure 5:
Health Services Division,
DSHS


COMMUNITY SERVICES DIVISION
Office of Blind
Serv. for Blind
Office of Veterans
Institutions
Bur. of Dev. Dis.
D. D. Institutions
Blind & Deaf Inst.
Case Services
Bur of Juv Rehab
Institutions
Probation Subsidy
Bur. of Soc. Serv
Aging
Alcoholism
Income Maintenance
Family, Children & Adult Services
Purchase of Services
Region I
Region II
Region III
Region IV
Region V
Region VI
Bur Mental Health
Institutions
Community M. H.

REGIONAL PROGRAMS

Adult Services
Alcoholism Contracts
Delinquency Prevention
Family & Children Services
Food Stamps
Income Maintenance
Juvenile Parole
Medicaid Eligibility
Veterans Contracts
Veterans Services

Figure 6

Community Services Division, DSHS

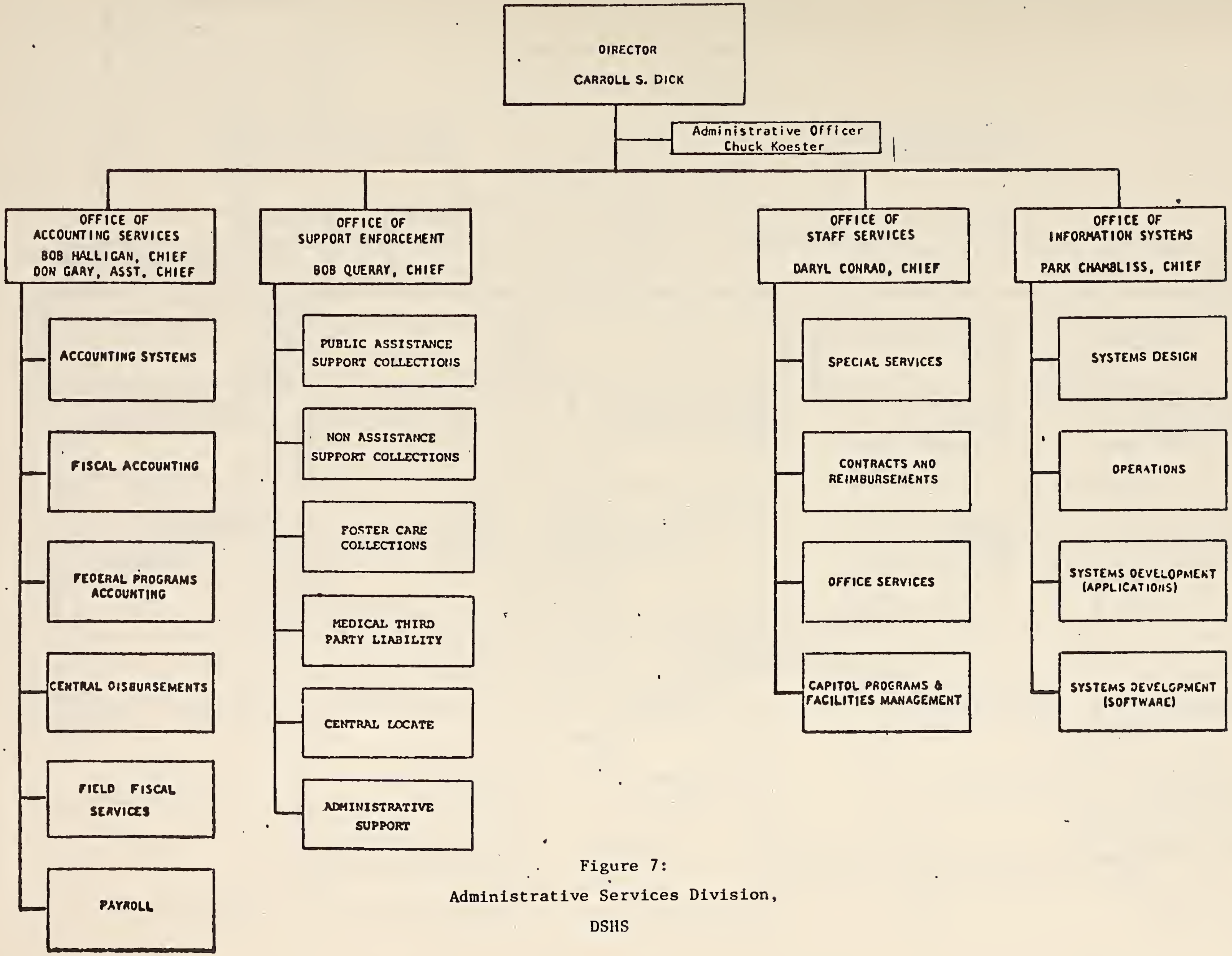

DIRECTOR
CARROLL S. DICK
Administrative Officer
Chuck Koester
OFFICE OF
ACCOUNTING SERVICES
BOB HALLIGAN, CHIEF
DON GARY, ASST. CHIEF
ACCOUNTING SYSTEMS
FISCAL ACCOUNTING
FEDERAL PROGRAMS ACCOUNTING
CENTRAL DISBURSEMENTS
FIELD FISCAL SERVICES
PAYROLL
OFFICE OF
SUPPORT ENFORCEMENT
BOB QUERRY, CHIEF
PUBLIC ASSISTANCE SUPPORT COLLECTIONS
NON ASSISTANCE SUPPORT COLLECTIONS
FOSTER CARE COLLECTIONS
MEDICAL THIRD PARTY LIABILITY
CENTRAL LOCATE
ADMINISTRATIVE SUPPORT
OFFICE OF
STAFF SERVICES
DARYL CONRAD, CHIEF
SPECIAL SERVICES
CONTRACTS AND REIMBURSEMENTS
OFFICE SERVICES
CAPITOL PROGRAMS & FACILITIES MANAGEMENT
OFFICE OF
INFORMATION SYSTEMS
PARK CHAMBLISS, CHIEF
SYSTEMS DESIGN
OPERATIONS
SYSTEMS DEVELOPMENT (APPLICATIONS)
SYSTEMS DEVELOPMENT (SOFTWARE)

Figure 7:
Administrative Services Division,
DSHS

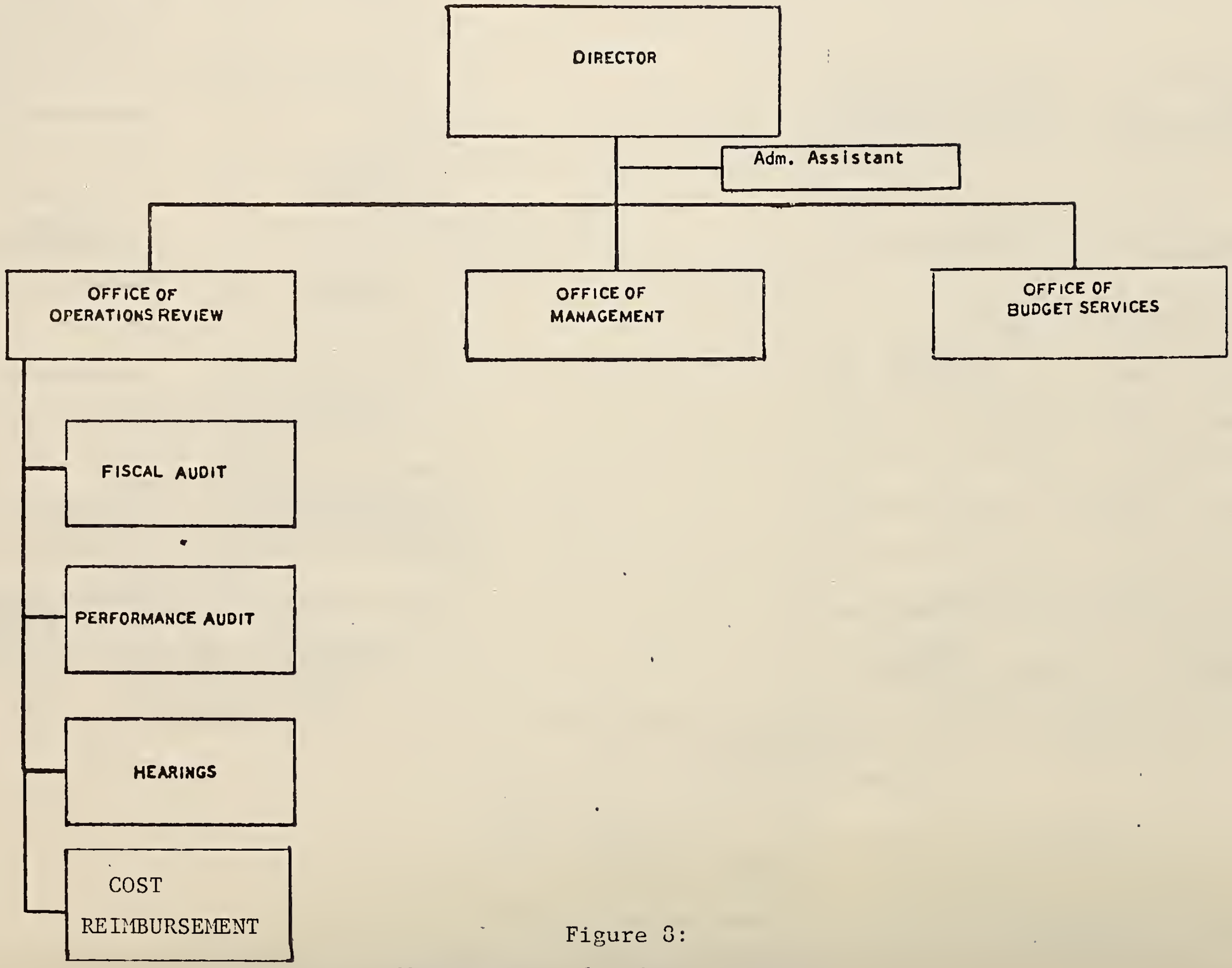

DIRECTOR
Adm. Assistant
OFFICE OF OPERATIONS REVIEW
OFFICE OF MANAGEMENT
OFFICE OF BUDGET SERVICES
FISCAL AUDIT
PERFORMANCE AUDIT
HEARINGS
COST REIMBURSEMENT

Figure 8:

Management and Budget Division,

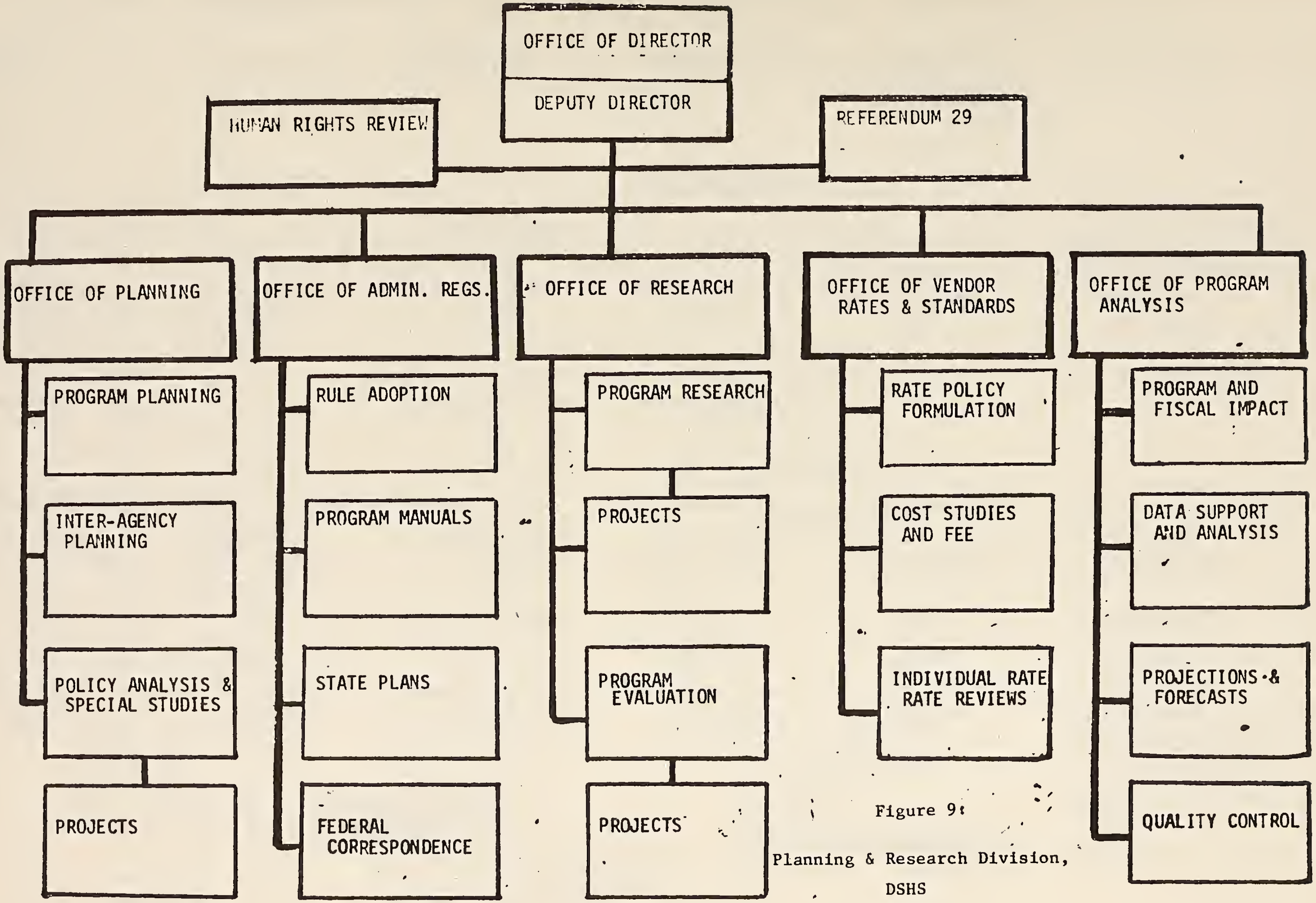

OFFICE OF DIRECTOR
DEPUTY DIRECTOR
HUMAN RIGHTS REVIEW
REFERENDUM 29
OFFICE OF PLANNING
PROGRAM PLANNING
INTER-AGENCY PLANNING
POLICY ANALYSIS & SPECIAL STUDIES
PROJECTS
OFFICE OF ADMIN. REGS.
RULE ADOPTION
PROGRAM MANUALS
STATE PLANS
FEDERAL CORRESPONDENCE
OFFICE OF RESEARCH
PROGRAM RESEARCH
PROJECTS
PROGRAM EVALUATION
PROJECTS
OFFICE OF VENDOR RATES & STANDARDS
RATE POLICY FORMULATION
COST STUDIES AND FEE
INDIVIDUAL RATE RATE REVIEWS
OFFICE OF PROGRAM ANALYSIS
PROGRAM AND FISCAL IMPACT
DATA SUPPORT AND ANALYSIS
PROJECTIONS & FORECASTS
QUALITY CONTROL

Figure 9:

Planning & Research Division,

DSHS

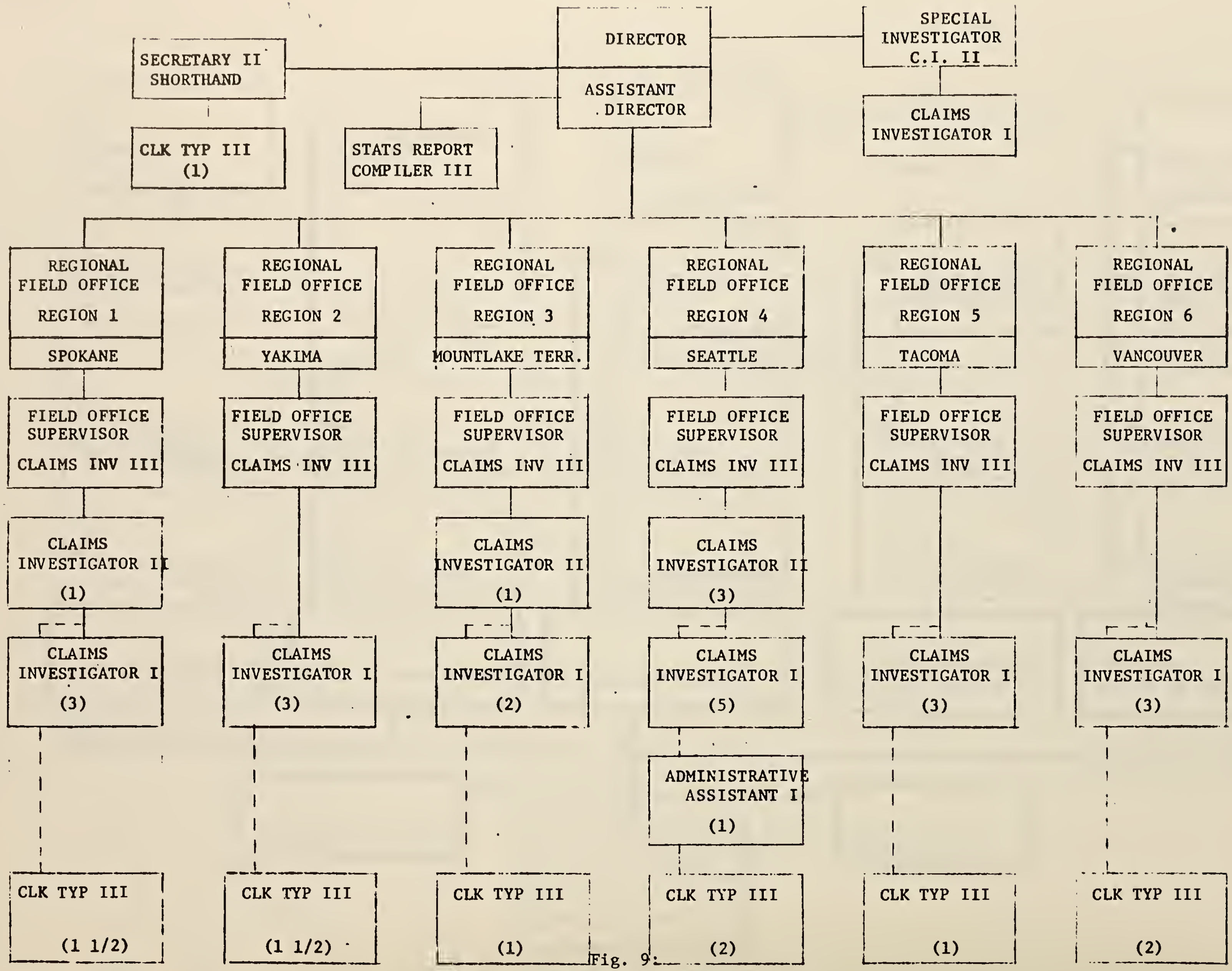

DIRECTOR
ASSISTANT DIRECTOR
SPECIAL INVESTIGATOR C.I. II
CLAIMS INVESTIGATOR I
SECRETARY II SHORTHAND
CLK TYP III (1)
STATS REPORT COMPILER III
REGIONAL FIELD OFFICE REGION 1
SPOKANE
FIELD OFFICE SUPERVISOR CLAIMS INV III
CLAIMS INVESTIGATOR II (1)
CLAIMS INVESTIGATOR I (3)
CLK TYP III (1 1/2)
REGIONAL FIELD OFFICE REGION 2
YAKIMA
FIELD OFFICE SUPERVISOR CLAIMS INV III
CLAIMS INVESTIGATOR I (3)
CLK TYP III (1 1/2)
REGIONAL FIELD OFFICE REGION 3
MOUNTLAKE TERR.
FIELD OFFICE SUPERVISOR CLAIMS INV III
CLAIMS INVESTIGATOR II (1)
CLAIMS INVESTIGATOR I (2)
CLK TYP III (1)
REGIONAL FIELD OFFICE REGION 4
SEATTLE
FIELD OFFICE SUPERVISOR CLAIMS INV III
CLAIMS INVESTIGATOR II (3)
CLAIMS INVESTIGATOR I (5)
ADMINISTRATIVE ASSISTANT I (1)
CLK TYP III (2)
REGIONAL FIELD OFFICE REGION 5
TACOMA
FIELD OFFICE SUPERVISOR CLAIMS INV III
CLAIMS INVESTIGATOR I (3)
CLK TYP III (1)
REGIONAL FIELD OFFICE REGION 6
VANCOUVER
FIELD OFFICE SUPERVISOR CLAIMS INV III
CLAIMS INVESTIGATOR I (3)
CLK TYP III (2)

Fig. 9.
Office of Special Investigations, DSHS

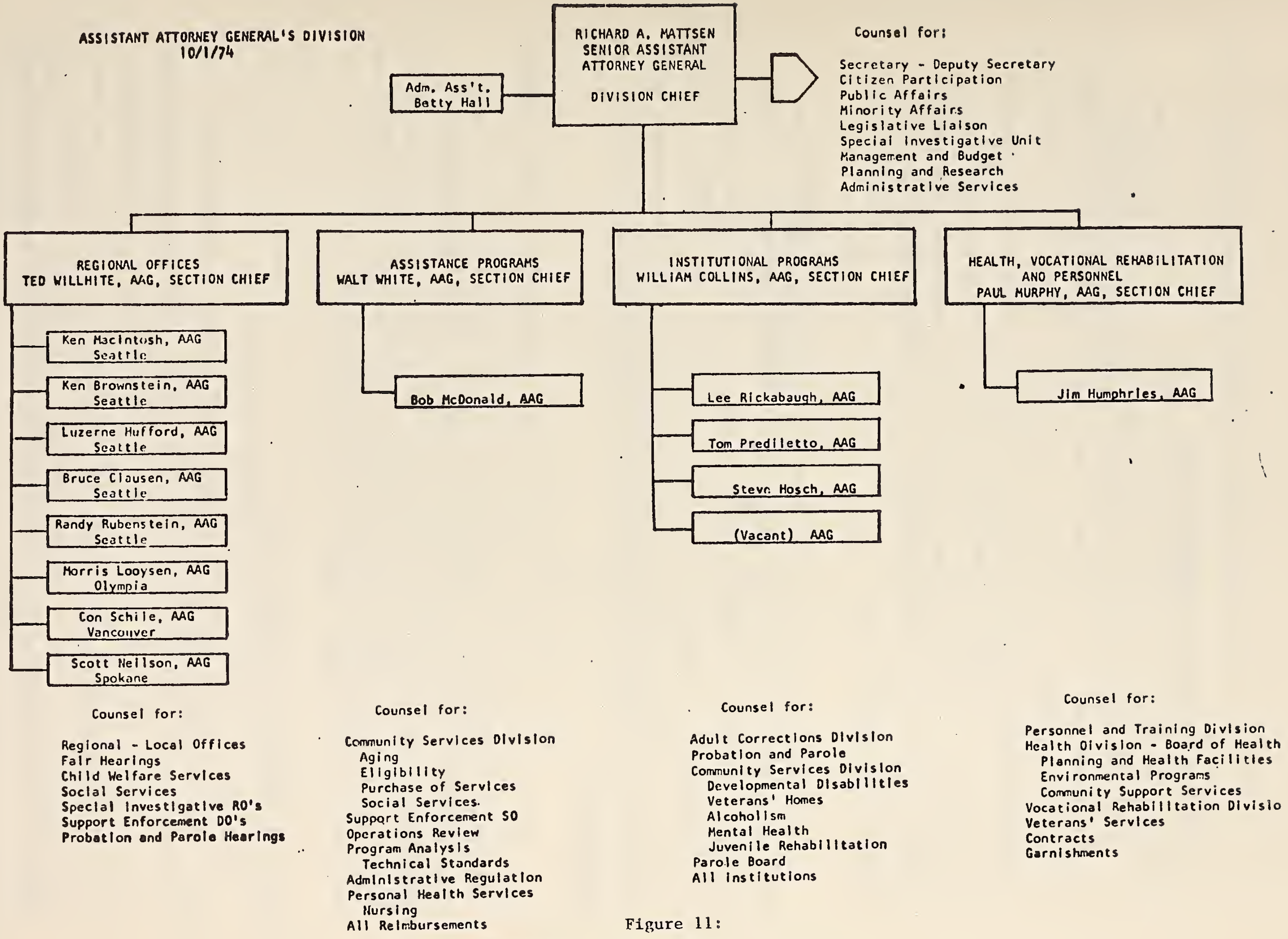

ASSISTANT ATTORNEY GENERAL'S DIVISION
10/1/74
Adm. Ass't.
Betty Hall
RICHARD A. MATTSEN
SENIOR ASSISTANT
ATTORNEY GENERAL
DIVISION CHIEF
Counsel for:
Secretary - Deputy Secretary
Citizen Participation
Public Affairs
Minority Affairs
Legislative Liaison
Special Investigative Unit
Management and Budget
Planning and Research
Administrative Services
REGIONAL OFFICES
TED WILLHITE, AAG, SECTION CHIEF
Ken Macintosh, AAG
Seattle
Ken Brownstein, AAG
Seattle
Luzerne Hufford, AAG
Seattle
Bruce Clausen, AAG
Seattle
Randy Rubenstein, AAG
Seattle
Morris Looysen, AAG
Olympia
Con Schile, AAG
Vancouver
Scott Neilson, AAG
Spokane
Counsel for:
Regional - Local Offices
Fair Hearings
Child Welfare Services
Social Services
Special Investigative RO's
Support Enforcement DO's
Probation and Parole Hearings
ASSISTANCE PROGRAMS
WALT WHITE, AAG, SECTION CHIEF
Bob McDonald, AAG
Counsel for:
Community Services Division
Aging
Eligibility
Purchase of Services
Social Services
Support Enforcement SO
Operations Review
Program Analysis
Technical Standards
Administrative Regulation
Personal Health Services
Nursing
All Reimbursements
INSTITUTIONAL PROGRAMS
WILLIAM COLLINS, AAG, SECTION CHIEF
Lee Rickabaugh, AAG
Tom Prediletto, AAG
Steve Hosch, AAG
(Vacant) AAG
Counsel for:
Adult Corrections Division
Probation and Parole
Community Services Division
Developmental Disabilities
Veterans' Homes
Alcoholism
Mental Health
Juvenile Rehabilitation
Parole Board
All Institutions
HEALTH, VOCATIONAL REHABILITATION
AND PERSONNEL
PAUL MURPHY, AAG, SECTION CHIEF
Jim Humphries, AAG
Counsel for:
Personnel and Training Division
Health Division - Board of Health
Planning and Health Facilities
Environmental Programs
Community Support Services
Vocational Rehabilitation Divisio
Veterans' Services
Contracts
Garnishments

Figure 11:

Assistant Attorney General's Division

3 CONTROL OF MEDICAID PROVIDER FRAUD

Medicaid fraud control is beginning a new phase in Washington. Previous fraud control activities focused on welfare recipients; now they are focusing on Medicaid providers. Previously, provider fraud prevention and detection activities were minimal because claims processing was done manually; now Washington is installing a Medicaid Management Information System (MMIS). Previously, most provider fraud cases involved recently-audited nursing homes; now computer-generated profiles can be used to examine all providers.

At the time of the site visit DSHS was still in transition from manual to automated operations, and therefore lacked results that might indicate the effectiveness of the new system. This report has been adapted to reflect DSHS's transient situation: descriptions of prevention, detection, and (to some extent) investigation techniques will alternate between "old" and "new" with comments on expected effectiveness based on other states' experiences.

Provider fraud control activities are undertaken by two offices in the Health Services Division (Office of Medical Assistance and Office of Nursing Home Affairs); the Office of Operations Review, Management and Budget Division; the Office of Special Investigation; the Assistant Attorney General's Division; and county prosecutors. The specific responsibilities of these units and their interaction is discussed below.

3.1 PREVENTION OF PROVIDER FRAUD

Prior to installation of the MMIS, provider fraud prevention was limited to what could be expected from a manual claims processing system -- gross screens, limits of services, prior authorization requirements for services and length of stay -- and indirect methods -- publicity,claimant certificat on claim form, provider education materials. The new MMIS will add significantly to DSHS's fraud prevention capabilities as the change from manual to automated claims processing introduces new fraud prevention tools and enhances the effectiveness of existing ones.

3.1.1 Medicaid Management Information System and Claims Processing

Implementation of the MMIS began in November 1975 when EDS-Federal, the claims processing agent, started onsite operation. Claims processing was phased in by provider type:

Pharmacy	February 2, 1976
Physician and Medical vendor	March 5, 1976
Hospital and Physician Crossover*	April 2, 1976
Nursing home, Congregate Care**, and Institutional Crossover	April 16, 1976
Dental	June 4, 1976

The first MMIS reports were produced at the end of June, 1976: Surveillance and Utilization Review System (SURS), Management and Administrative Reports System (MATS) and recipient Explanation of Medical Benefits (EOMB). MMIS certification was to be requested in July, 1976.

The MMIS being installed is of EDS design. It consists of seven information modules standard to MMIS, slightly modified for the Washington environment. Basically DSHS is implementing the complete MMIS, with standard pre-pay edits for duplicate and erroneous billing, eligibility checks, date of death, compliance with amount, duration, scope of benefits, etc.; and standard post-pay retrospective review tools (provider and patient profiles and ratios of services, EOMB/VOS). Initially, the MMIS is expected to be very effective in preventing overpayment by pre-pay claims denial. The number of fraudulent rather than erroneous overbillings in these denials will probably not be determined.

---

* "Crossover" refers to Mixed Medicare and Medicaid Claims.

** "Congregate care" is a non-medical board and care living situation.

All provider claims are submitted on DSHS-supplied forms to the Office of Medical Assistance, Olympia. After receipt they are microfilmed, then manually checked for completeness and timeliness.* Each claim must be

- accompanied by a valid recipient Medical Identification Coupon (original or photocopy);
- signed by the provider;
- numerically coded to identify services.**

Claims lacking any of these items may be either denied and returned to the provider or flagged and set aside for review.

DSHS requires other supporting documentation for certain claims. For instance, a consultant or specialist report must accompany each claim of this type. Anesthesiologists' and surgical assistants' claims must cross-reference the surgeon and show the patient's diagnosis. Hospital claims must show a diagnosis and physician's name. Pharmacy claims must have the prescriber's name and Bureau of Narcotics number and show a specified unit and interval dose.

Complete claims are keypunched, then sent to EDS in San Francisco where actual processing is done. Claims passing all edits are affirmed for payment; those failing edits are remanded to DSHS. At the time of the site visit, procedures for handling remanded claims had not yet been set. Under the manual system, utilization review activities and questions of medical necessity were under the direction of Dr. Wesley Brock, assisted by regional consultants.

Providers must accept DSHS-determined payment as full satisfaction of the claim. Recipients may not be billed for the difference between provider charges and DSHS payment.***

---

* Claims may be submitted anytime after service, but at least monthly. After final service is rendered, a provider must submit the final claim within 60 days. Nursing homes bill between the 25th and the end of each month.

** Pharmacy claims use the National Drug Code (NDC); all other providers use Current Procedural Terminology, third edition (CPT-3).

*** There is one exception: nursing homes may collect from recipients who must meet spend-down requirements. DSHS determines the spend-down amount and notifies the nursing home.

3.1.2 Limitations on Amount, Duration and Scope

Although limiting medical benefits is usually considered a control for overutilization, it can also be considered a fraud prevention device if the limits are imposed on easily-abused services. DSHS limits the following services:

- physicians:
  - 1 outpatient visit per month*
  - 1 inpatient visit per day
  - 2 nursing home visits per month
- chiropractors: 3 treatments per month to a limit of 20*. No out-of-state service or other services (light, heat, hydrotherapy, physiotherapy, etc.)
- podiatrists: only for diagnosis or treatment of illness, injury or malformation. No routine foot care.
- drugs: over-the-counter drugs, drugs regularly supplied by other agencies or programs, drugs for inpatients or prepaid enrollees are excluded.
- physical and speech therapy: inpatient therapy is excluded.
- mental health: only in facilities holding a contract with DSHS.

Prior authorization from the local medical consultant is required for these services:

- all services for MO category
- all hospital admissions except emergency
- all LOS past the PAS 75th percentile
- all surgery and x-ray therapy, except emergency
- all non-formulary drugs costing over $15
- psychologist consultation (testing and evaluation) in connection with diagnosis and treatment
- all nursing home admissions

---

* Prior authorization may be requested to extend service.

- special nursing care
- all out-of-state drug and certain other out-of-state services
- speech therapy
- inhalation therapy over 5 treatments
- outpatient physical therapy
- home oxygen for recipients under 65
- medical products (appliances, prostheses, eyeglasses and exams, etc.)

Additional prior authorization from the State office is required for special duty nursing, non-emergency surgery, reusable medical appliances costing over $50, non-reusable surgical appliances costing over $100 (with a few exceptions), rental of all durable medical equipment, and repair of equipment.

A valid prior authorization form must accompany claims for limited services.

3.1.3 Cost Reimbursement for Institutional Providers

Washington, as other states, uses a cost-related reimbursement system for paying institutional providers. Because of this system's potential for abusive and fraudulent financial manipulation, Washington added sections to its Administrative Code specifically defining reporting requirements, penalties for false reports, accounting method, reimbursement system, establishing of rates and revisions, billing instructions, allowable and non-allowable costs, and method of appeals. The new sections, which are quite extensive, are reproduced in Exhibit F.

The code additions were written by the Cost Reimbursement Section, Office of Operations Review, Management and Budget Division. (See Figures 12 and 13 .)* A relatively new section, it has had responsibility for developing the nursing home cost reimbursement system -- establishing and validating cost baselines,

---

* Other Sections of the Office of Operations Review involved in fraud control activities are Fiscal Audit (annual financial audit of institutions) and Hearings (recipient appeals). They are discussed in later sections.

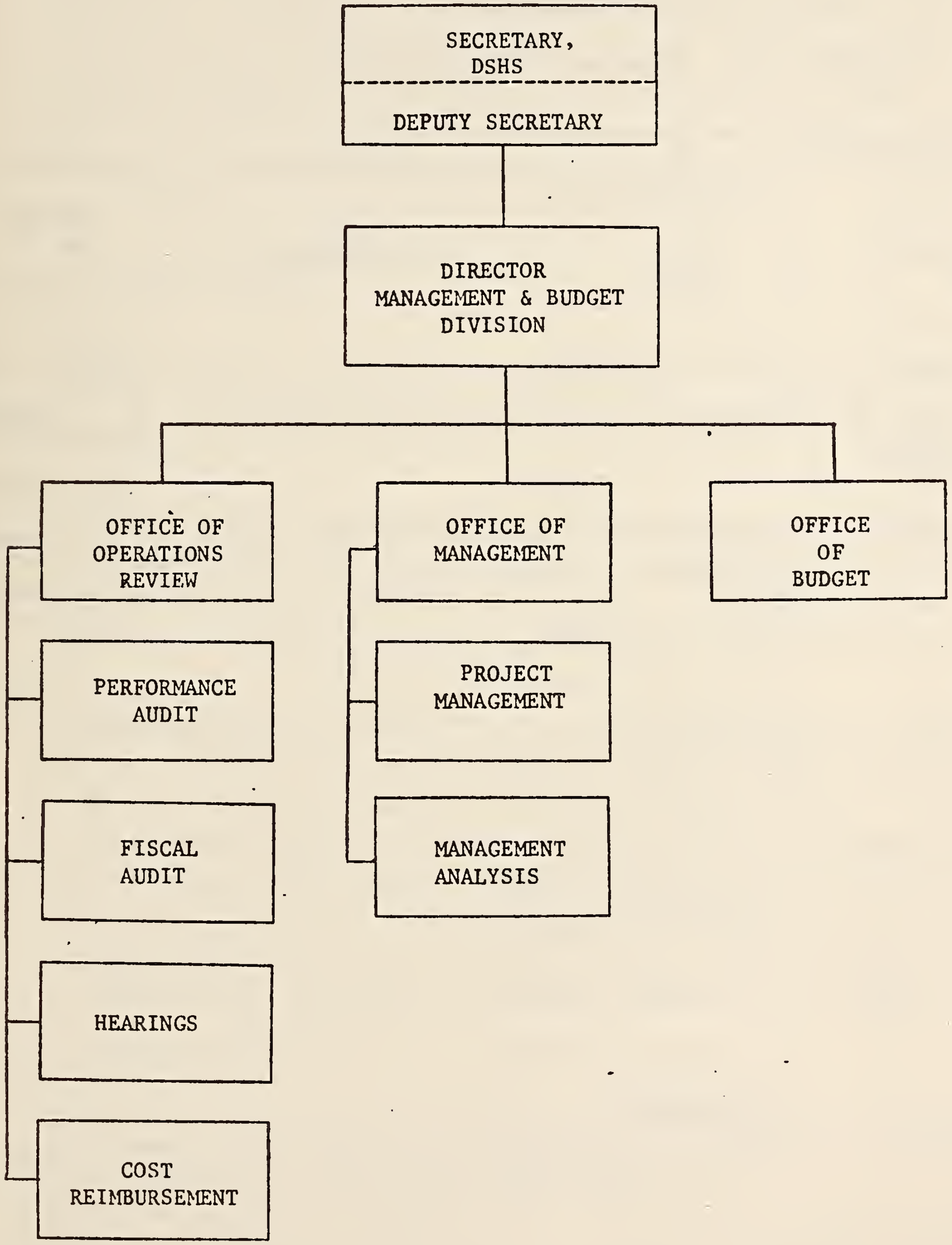

SECRETARY, DSHS
DEPUTY SECRETARY
DIRECTOR MANAGEMENT & BUDGET DIVISION
OFFICE OF OPERATIONS REVIEW
OFFICE OF MANAGEMENT
OFFICE OF BUDGET
PERFORMANCE AUDIT
PROJECT MANAGEMENT
FISCAL AUDIT
MANAGEMENT ANALYSIS
HEARINGS
COST REIMBURSEMENT

Figure 12

Placement of Office of Operations Review Within DSHS

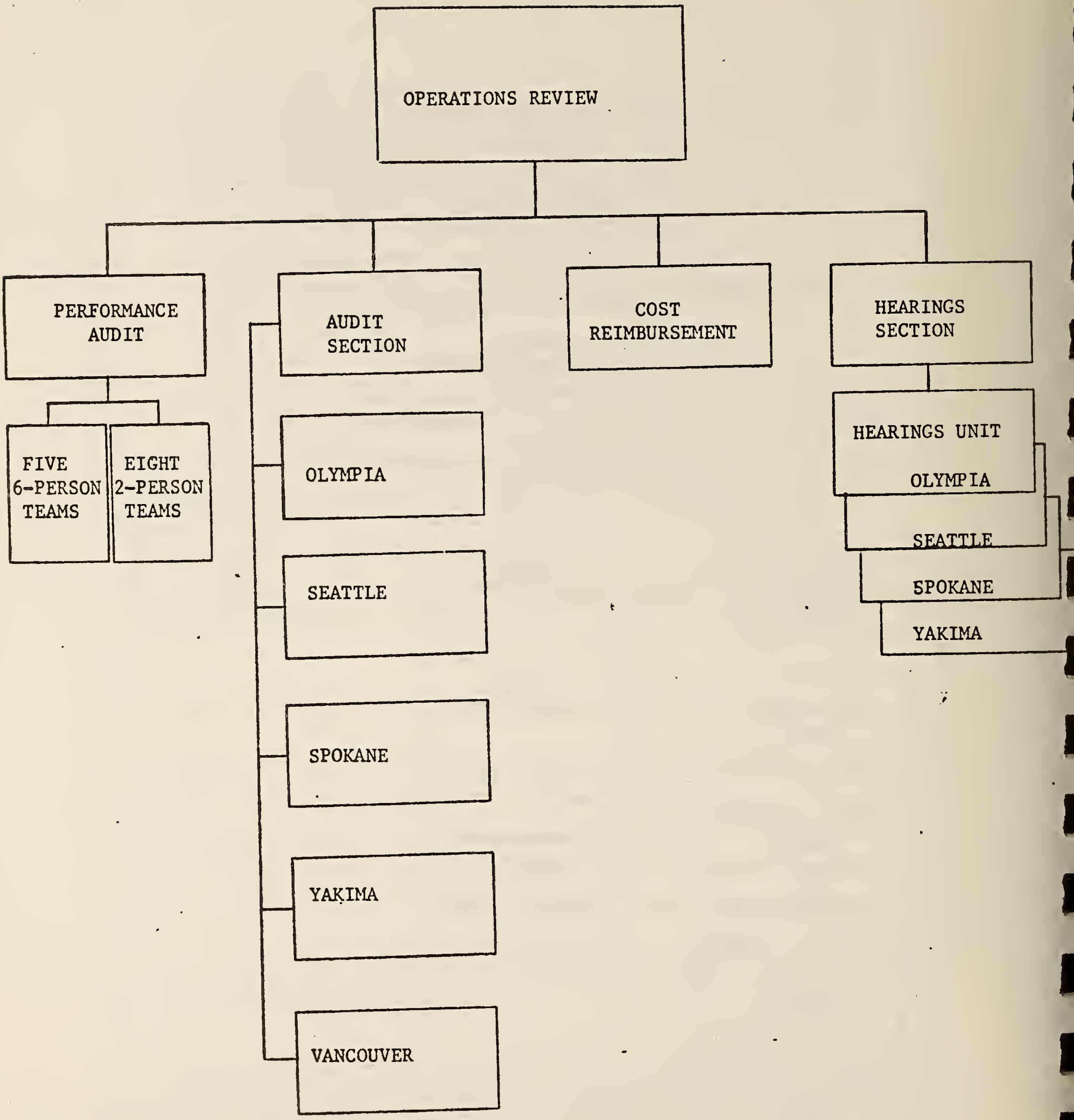

OPERATIONS REVIEW
PERFORMANCE AUDIT
FIVE 6-PERSON TEAMS
EIGHT 2-PERSON TEAMS
AUDIT SECTION
OLYMPIA
SEATTLE
SPOKANE
YAKIMA
VANCOUVER
COST REIMBURSEMENT
HEARINGS SECTION
HEARINGS UNIT
OLYMPIA
SEATTLE
SPOKANE
YAKIMA

Figure 13

Organization Chart of Office of Operations Review determining reasonable charges, setting reporting requirements and accounting standards, issuing billing instructions, developing procedures for rate revisions, etc. Implementation of the newly-developed system was initially overseen by the Cost Reimbursement Section. However, that responsibility was recently transferred to the Office of Nursing Home Affairs (ONHA), to be integrated with survey, patient assessment, and provider consultation functions. The Operations Review Cost Reimbursement Section will now be free to develop similar systems for other types of instituional providers.[*]

3.1.4 Provider Relations

DSHS recognizes the contribution of good provider relations to fraud prevention. It provides materials and services both routinely and by special request.

Provider Manuals, Billing Instructions, and Billing Forms: Routinely provided by DSHS, the provider manuals contain information on recipient eligibility, covered services, and billing. In addition, separate detailed and illustrated billing instructions are provided with claim forms.

Remittance Advice: Mailed weekly to providers whose accounts have been active, the remittance advice provides detailed financial information that can be used to determine the status of submitted claims. It contains six sections: Paid Claims for the current week; Financial Transactions other than normal claims payments[**]; Pending Claims that have been in the claims processing system over 20 days; Returned Claims for the current week; Claims Payment Summary both current and year-to-date; and Messages which translate explanation codes to narration. Exhibit G is an example of Remittance Advice.[***]

---

[*] The Cost Reimbursement Section also sets minimum standards of care for nursing homes. Homes failing to meet standards may have either "stop placement" or "stop payment" sanctions ordered against them.

[**] DSHS has authority to withhold from current billings to satisfy previous overpayments.

[***] The Remittance Advice is a product of the MMIS. Accompanying it is an explanation of what it contains and how to use it.

Memoranda: These are mailed whenever necessary to inform providers of policy decisions or other changes affecting Title XIX. Exhibit H is a memorandum explaining a policy change that enabled providers to use mechanically-prepared continuous claim forms.

Consultation Services: Provided primarily by the Office of Operations Review, providers may request billing assistance or other similar services.

3.1.5 Other Measures

In addition to practices with a demonstrable effect on the incidence of fraud, there are practices whose deterrant effect is hard to establish, but which are subjectively judged to be worthwhile. DSHS uses these standard devices.

Each claim bears a "Claimant Certificate" that must be signed before processing can begin. The Certificate is identical for all providers:

> "I hereby certify under penalty of perjury, that the material furnished and service rendered is a correct charge against the State of Washington; the claim is just and due; that no part of same has been paid and I am authorized to sign for the payee; and that all goods furnished and/or services rendered have been provided without discrimination on the grounds of race, creed, color, or national origin."

In July DSHS first mailed Explanation of Medicaid Benefits (EOMB) forms to recipients. About 6000 had been returned by the time of the site visit. In the experience of other states, EOMBs first function as a fraud detection device; only later do they also become a deterrance to fraud.

Through professional organizations and associations DSHS personnel have become acquainted with people in other states who are also active in fraud control. This has resulted in an informal data exchange network. Department heads contact professional acquaintances in other states to learn how a particular kind of fraud is being controlled, or may give and receive "tips" on providers with questionable billing practices who are moving from state to state.

DSHS has used publicity as a fraud deterrant by granting newspaper and television interviews with the head of the Office of Special Investigations. Once used extensively, the effort has lately been abandoned as it was thought to be undermining confidence in DSHS, and giving OSI an undesirable image. Exhibit I is an example interview.

3.2 DETECTION OF PROVIDER FRAUD

As long as DSHS was processing claims manually, detection of provider fraud was limited to flagrant cases noticed during claims processing, utilizing review, or determination of medical necessity for prior authorization of services. Detection relied on individuals rather than procedures. The switch to automated claims processing is changing this. The MMIS is beginning to produce provider profiles, exception reports, audits, and similar claims-based information that can be analyzed for questionable billing practices.

The limits on fraud detection activities inherent in the manual claims processing system have caused greater visibility of fraud committed by institutional providers, particularly nursing homes, than by practitioners. Because DSHS uses a cost-reimbursement system for establishing nursing home rates, it conducts an annual financial audit of all nursing homes receiving Title XIX payments. Part I of the audit process focuses on possible fraud.

Audits are conducted by the Fiscal Audit Section of the Office of Operations Review (see Figure 9 previously) and by the Office of Nursing Home Affairs (see Figure 5 previously). The Fiscal Audit Section performs about 2100 audits a year -- 900 "mini" audits by a 2-person team, and 1200 full audits by a 6-person team. (These numbers include hospital audits as well as nursing homes.*)

A typical audit begins when the Audit Section contacts the institution to be audited and they agree on a date. The audit is performed on-site and concludes with an exit interview. The audit team returns to its regional office and prepares a final audit report. This report spells out the institution's degree of compliance with regulations. The report cites the criteria to be met, describes any variances, gives the cause (if known), describes the effect of the variance, and recommends action. Institutions have 45 days to make corrections and file a report. Verification that the institution is complying may be made by field check after the 45-day limit has expired or may wait until the next scheduled audit.

---

* The Audit Section is responsible for auditing all internal DSHS divisions and any external agencies receiving funds from or through DSHS -- developmental disability centers, mental institutions, alcoholism centers, nursing homes and hospitals.

One particular type of nursing home provider fraud -- misuse of patient trust fund accounts* -- was repeatedly found by audit teams.** The Office of Operations Review responded by writing a manual covering nursing home responsibilities in handling patient funds. It includes a suggested bookkeeping system***, copies of relevant parts of the Provider Agreement, WAC, RCW (Revised Code of Washington), or federal regulations substantiating the need for the system, and models to illustrate the narrative description. The manual, without statutory inclusions, is reproduced in Exhibit J.

DSHS's use of audits as a fraud detection tool is illustrated by a recent change in the format of disallowance logs. These forms are used by field audit teams to record costs reported by the nursing home but adjusted by the audit team. Entitled "Summary of Concerns", it has a large explanation column that can be used to note instances of suspected or potential fraud. The form is easily reviewed for possible referral to the Office of Special Investigations.**** (See Exhibit K.)

The Office of Nursing Home Affairs (ONHA) also conducts audits through its Nursing Home Survey Section. Unlike the Office of Operations Review's Fiscal Audit Section, which audits cost-reimbursement claims***** and patient trust fund accounts, the Nursing Home Survey Section is concerned with whether Title XIX standards for nursing homes are being met. Nevertheless, auditors are alert for indications of possible fraud and may make referrals to OSI.

---

* DSHS pays each nursing home patient $25 a month to be used for personal expenses.

** One of the most "innovative" misuses of patient funds found was a nursing home administrator who bought life insurance policies on patients, named himself as beneficiary, and paid the premiums from patient trust funds.

*** A draft of the system was sent to all nursing homes and responses were invited before the system was finalized.

**** The Summary has other potential applications as well: 1) aiding settlement; 2) cueing areas of concern for future audits; 3) assisting in uniform application of cost-reimbursement principles; 4) serving as data for provider or auditor training programs.

***** Note that this function was recently transferred to the Cost Reimbursement Section of ONHA.

Other ONHA sections involved in provider fraud detection are Patient Review (utilization review) and Cost Reimbursement (taking over responsibilities from the Office of Operations Review). Nursing home utilization review is performed by nursing care consultants (RNs). Thirty consultants are in the field at all times; annually a team comprised of a nursing care consultant, a social worker, and a medical consultant conducts a medical care review which may pick up discrepenacies to be investigated by OSI.

DSHS requires vendors to nursing homes to disclose their business relationship within the home. Vendors that are wholly owned by nursing homes, or nursing homes wholly owned by vendors must be identified. This applies to medical and non-medical vendors, such as linen supply, paper products, food distributors, etc.

Other institutional providers besides nursing homes may be audited. DSHS has written a Laboratory Review Guide "intended to provide a structured process for reviewing claims submitted for laboratory services. It...provides an audit review capability to detect certain improper billing practices which may in turn be indicative of potential fraud or abuse."*

The Guide sets out four phases of review:

1. Preliminary review to learn DSHS regulations, guidelines, and claims processing practices for laboratories; and to develop profile information or the laboratory to be reviewed.

2. Field review to secure documentation, survey lab equipment, interview the lab director, and verify completeness of information collected thus far.

---

* DSHS Laboratory Review Guide, Office of Special Investigations, Health Care Services Division, p.1.

3. Desk review to review and verify documentation and findings.

4. Final review to summarize findings.

During each review phase the reviewer must complete one or more forms marking his progress. LAB-1 tests the reviewer's knowledge of DSHS regulations; LAB-2 develops the individual lab profile (Phase 1). LAB-3 and LAB-4 are claims worksheets; LAB-5 is the equipment survey report; LAB-6 is a data collection checklist; LAB-7 is the lab director interview guide (Phase 2). Using LAB-8 a reviewer can contact prescribers to verify claims; LAB-9, "Potential Abuse Measurement", is used to collect information on suspected claims and assign each an "Abuse Code Number". Abusive practices are grouped -- Service Verification, Test Performance, Charge Pattern; LAB-10 summarizes LAB-9 (Phase 3). LAB-11, "Medicaid Provider Review Smmary Report", reports the findings of the review (Phase 4). The Guide and LAB forms are reproduced in Exhibit L.

In July, 1976, DSHS first mailed recipients an Explanation of Medicaid Benefits (EOMB) form (see Figure 14). Instructions addressed to the recipient were printed on the form. They asked the recipient to circle any services that were billed to him, or not provided, and to return the EOMB. A return envelope was not provided.

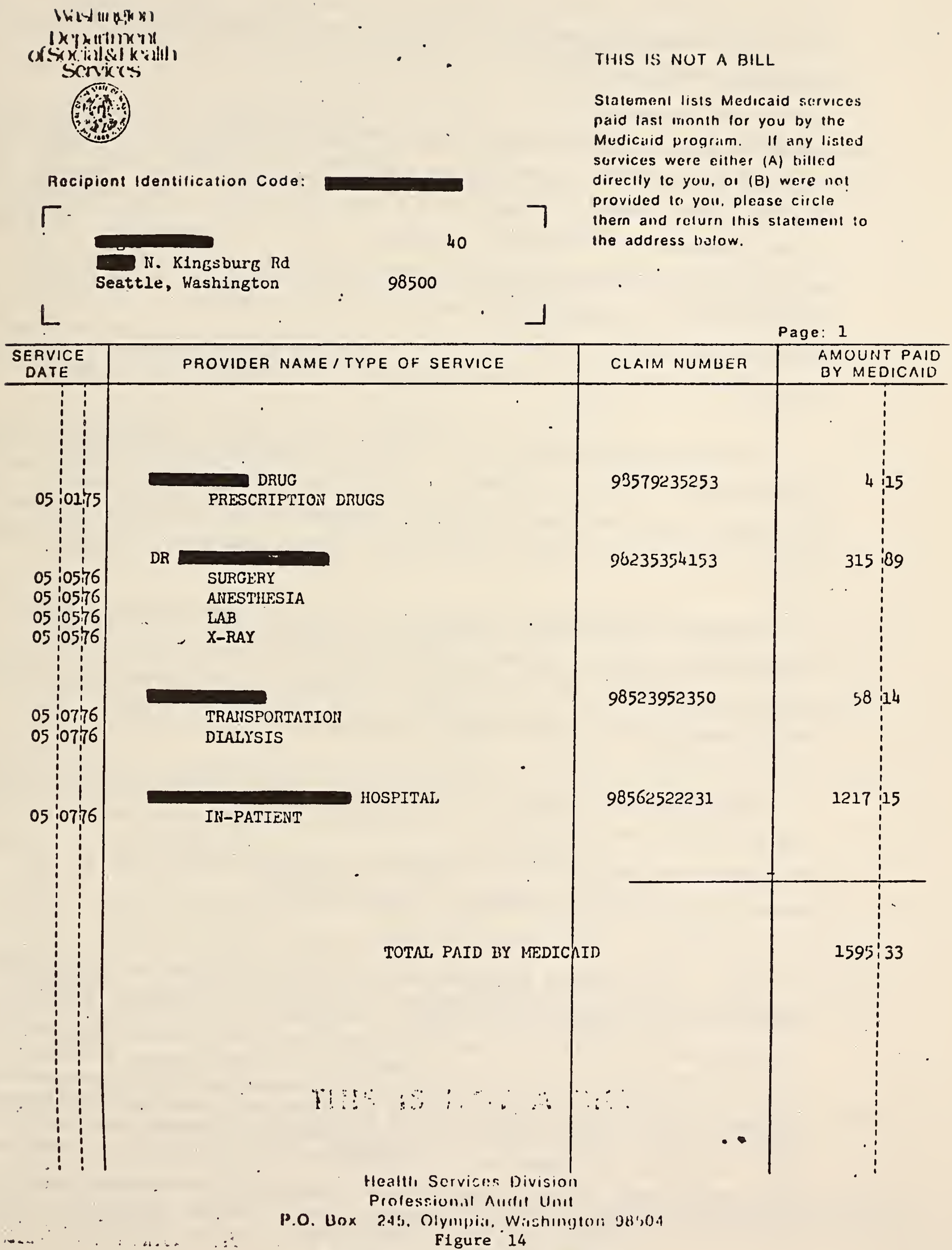
DSHS plans to mail EOMBs monthly to 100% of its Title XIX recipients. From the July mailing, about 6000 EOMBs had been returned by the time of the site visit. Informal analysis of the returns showed expected results -- many recipients were confused by the EOMB and consequently responded incorrectly. DSHS expects the reliability of future returns to rise as recipients begin to understand the EOMB.*

3.3 INVESTIGATION OF PROVIDER FRAUD

Investigation of Medicaid provider fraud is the responsibility of the Office of Special Investigations (OSI). Until now, most provider cases have involved nursin homes (referred from ONHA or the Office of Operations Review) or other non-physician

---

* There were some "good" returns even on the first mailing. OSI received 5 separate "services not provided" EOMBs on one pharmacy.



Washington
Department
of Social & Health
Services

THIS IS NOT A BILL

Statement lists Medicaid services paid last month for you by the Medicaid program. If any listed services were either (A) billed directly to you, or (B) were not provided to you, please circle them and return this statement to the address below.

Recipient Identification Code: [redacted]

[redacted] 40
[redacted] N. Kingsburg Rd
Seattle, Washington 98500

Page: 1

SERVICE DATE	PROVIDER NAME / TYPE OF SERVICE	CLAIM NUMBER	AMOUNT PAID BY MEDICAID
	[redacted] DRUG	93579235253	4 15
05 01 75	PRESCRIPTION DRUGS		
	DR [redacted]	96235354153	315 89
05 05 76	SURGERY		
05 05 76	ANESTHESIA		
05 05 76	LAB		
05 05 76	X-RAY		
	[redacted]	98523952350	58 14
05 07 76	TRANSPORTATION		
05 07 76	DIALYSIS		
	[redacted] HOSPITAL	98562522231	1217 15
05 07 76	IN-PATIENT		
	TOTAL PAID BY MEDICAID		1595 33

THIS IS NOT A BILL

Health Services Division
Professional Audit Unit
P.O. Box 245, Olympia, Washington 98504

Figure 14
Explanation of Medicaid Benefits

providers.* This is expected to change as the MMIS develops provider profiles and other detection tools.

The first fraud investigation unit was established in 1948 at the King County Welfare Office. Fraud investigation remained at the county level until 1955 when the first state investigative unit was established. Responsibility reverted to the counties from 1959-1974, although in 1962 a new state unit was created and later transferred to the Support Enforcement Unit. In 1971 the state unit was separated from Support Enforcement and Robert Neilson, the present director, was named supervisor. Effective July 1, 1973 the state unit was enlarged, reorganized, and renamed. That state unit, with minor changes, is OSI today.

OSI has 48 supervisory, investigative and clerical personnel in total. State headquarters are in Olympia. Personnel in this office include the state OSI Director and Assistant Director; a specialist in forged warrants and a data-gathering resource person; a statistical reports analyst; and a secretary.

The State office plans, develops, directs and coordinates a statewide fraud investigation effort. It has responsibility for supervising operations in six regional offices.** The state office may conduct some investigations, but most investigations are conducted by regional office personnel.

The Regional Offices are staffed with a Field Office Supervisor, Claims Investigators, and secretaries. The size of the Office depends on the AFDC caseload: one investigator is assigned for every 2000 AFDC cases. Secretarial support varies with the number of investigators.

---

* Note, however, that prior to 1974, OSI focused almost exclusively on AFDC recipient fraud and allegations of employee misconduct. Medicaid provider fraud investigations were, in a sense, the result of a 1974 reorganization of DSHS and the change from flat-rate to cost-reimbursement for nursing homes. As the newly-created Cost-Reimbursement Section of the Office of Operations Review developed and implemented the cost-reimbursement system, and the Fiscal Audit Section began to audit nursing home financial matters, cases of possible fraud were gradually discovered and referred to OSI. OSI still gets most of its provider fraud referrals from these two sources.

** Coincidentally, one Regional Office (Vancouver) is located with the State Office in Olympia.

Investigators are recruited from closely-related professions: retired military police, insurance investigators, civilian police force, etc. Training is given on-the-job with the aid of a written manual. Considerable effort was put into the manual which is not a training device, but an operations guide. It includes a brief history of fraud investigation in Washington, a statement of OSI objectives and organization, and a description of the problem of welfare fraud.

The bulk of the manual describes operating procedures. Topics include:

- source of referrals to OSI
- the OSI Log Card*
- referrals from OSI to prosecutors
- investigative techniques
- personal conduct of investigators
- miscellaneous administrative matters
- public information policy

The section on "Investigation Techniques" contains much useful information: use of Miranda warning; interviewing; locating people; writing reports; sources of information; knowledge and use of evidence; the "portrait parle" or "spoken picture" technique of description. The manual concludes with appendices of legal definitions, testifying in court, common tactics of cross-examination, and the OSI file system. The Operating Manual is included as Exhibit N.

At the state level, Medicaid provider fraud cases are routinely referred from ONHA, Operations Review, and Claims Processing; occasionally from Bureau of Health Insurance (BHI); with increasing frequency from the MMIS; and expected from EOMBs. The flow of referrals is illustrated in Figure 15. At the Regional level cases come mainly from the OSI State Office; caseflow is almost identical to the State Office (see Figure 16).

---

* The OSI Log Card is a summary of action taken on any case. For active cases it serves to track progress; for completed cases it becomes the basis for statistical compilations. See Exhibit M.

** Inappropriate cases are referred to another agency. Some cases may be refused because the dollar amount is small (under $250 in all counties but King where the limit is $500) or the case clearly does not involve fraud.

Special Investigative Section Headquarters, Olympia

FLOW OF INCOMING COMPLAINTS

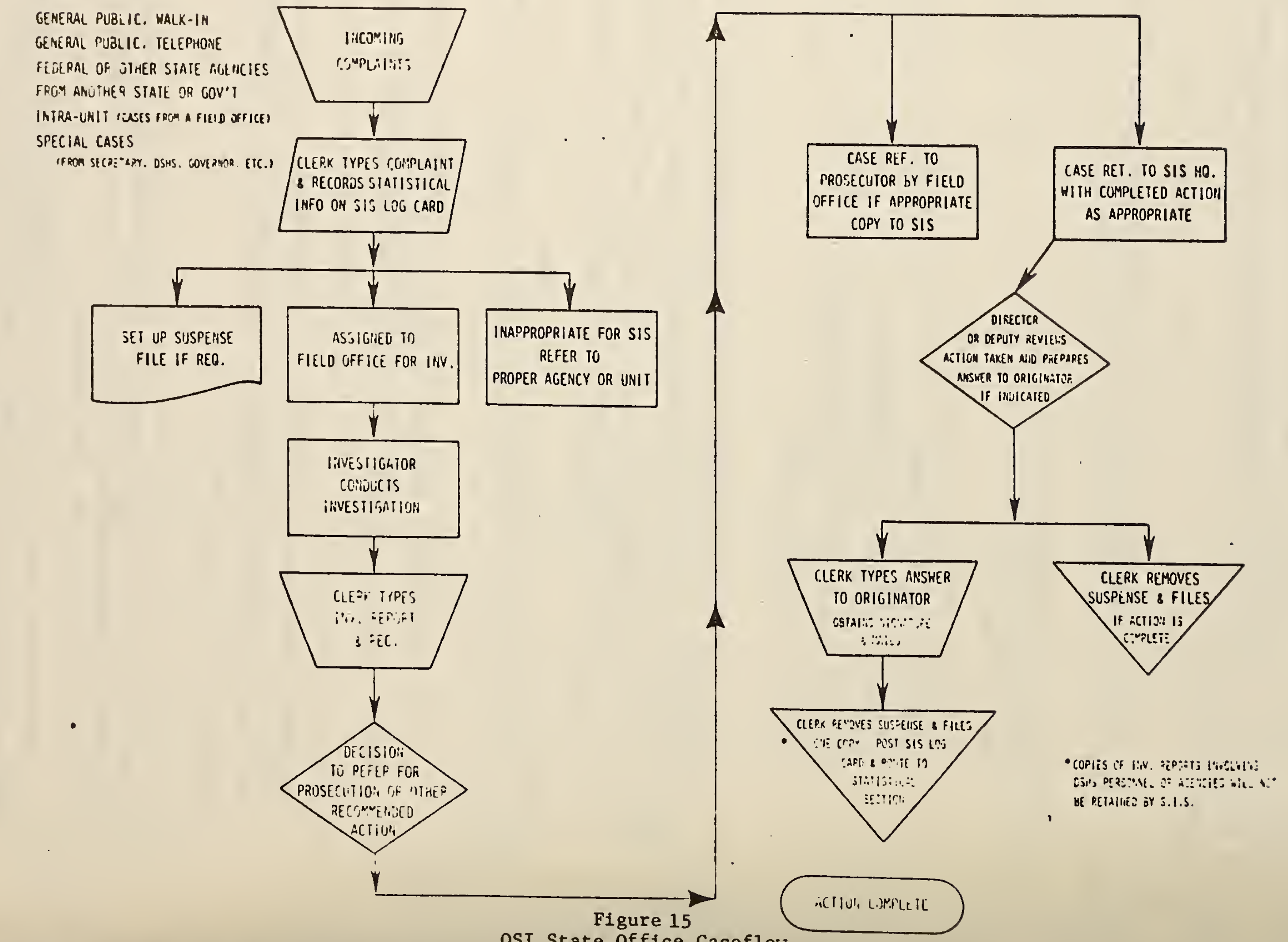

GENERAL PUBLIC. WALK-IN
GENERAL PUBLIC. TELEPHONE
FEDERAL OR OTHER STATE AGENCIES
FROM ANOTHER STATE OR GOV'T
INTRA-UNIT (CASES FROM A FIELD OFFICE)
SPECIAL CASES
(FROM SECRETARY. DSHS. GOVERNOR. ETC.)
INCOMING COMPLAINTS
CLERK TYPES COMPLAINT & RECORDS STATISTICAL INFO ON SIS LOG CARD
SET UP SUSPENSE FILE IF REQ.
ASSIGNED TO FIELD OFFICE FOR INV.
INAPPROPRIATE FOR SIS REFER TO PROPER AGENCY OR UNIT
INVESTIGATOR CONDUCTS INVESTIGATION
CLERK TYPES INV. REPORT & REC.
DECISION TO REFER FOR PROSECUTION OR OTHER RECOMMENDED ACTION
CASE REF. TO PROSECUTOR BY FIELD OFFICE IF APPROPRIATE COPY TO SIS
CASE RET. TO SIS HQ. WITH COMPLETED ACTION AS APPROPRIATE
DIRECTOR OR DEPUTY REVIEWS ACTION TAKEN AND PREPARES ANSWER TO ORIGINATOR IF INDICATED
CLERK TYPES ANSWER TO ORIGINATOR
OBTAINS SIGNATURE
CLERK REMOVES SUSPENSE & FILES IF ACTION IS COMPLETE
CLERK REMOVES SUSPENSE & FILES ONE COPY POST SIS LOG CARD & ROUTE TO STATISTICAL SECTION
*COPIES OF INV. REPORTS INVOLVING DSHS PERSONNEL OR AGENCIES WILL NOT BE RETAINED BY S.I.S.
ACTION COMPLETE

Figure 15
OSI State Office Caseflow

Special Investigative Section Field Office

SOURCE DOCUMENT FLOW CHART

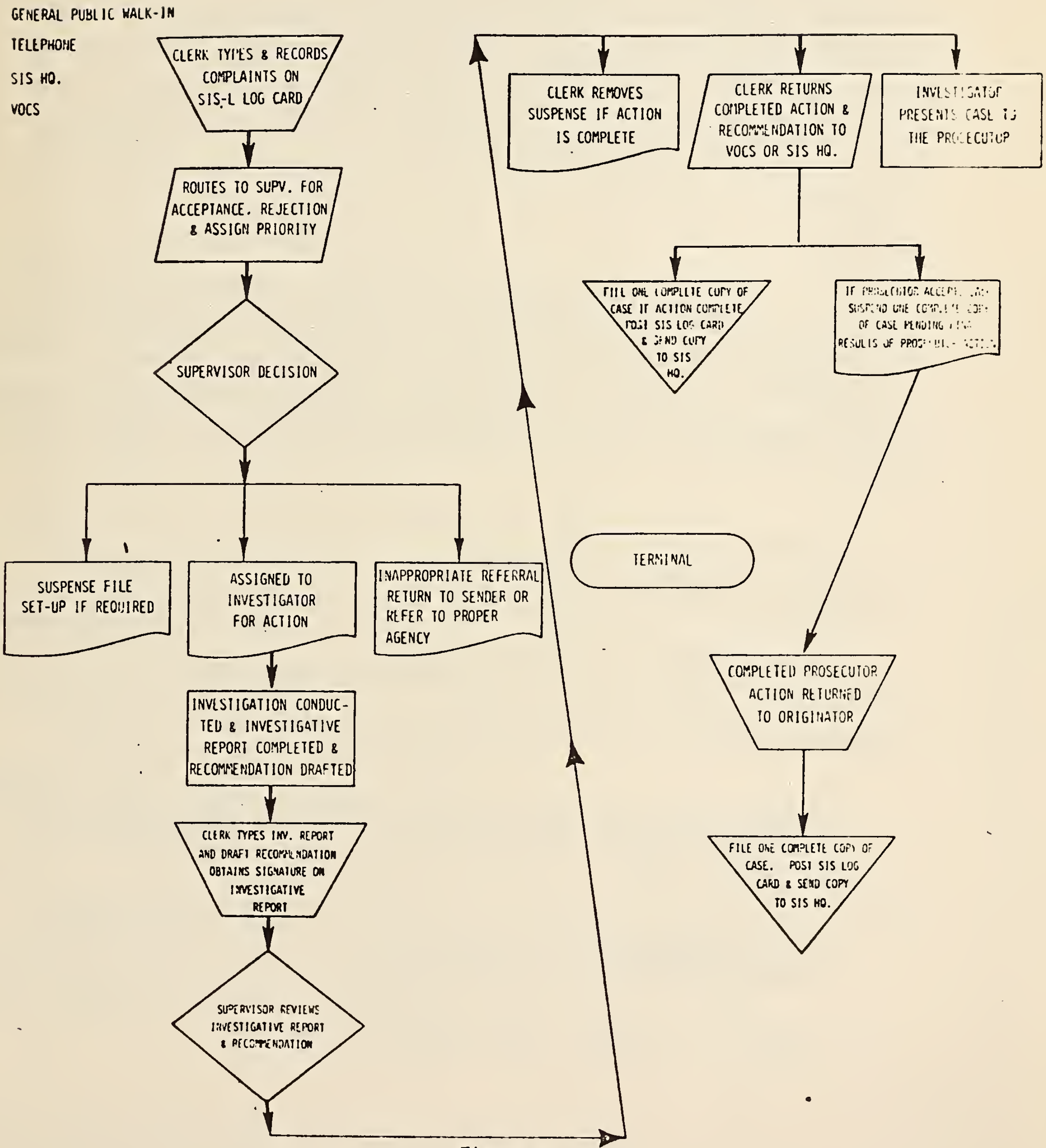

GENERAL PUBLIC WALK-IN
TELEPHONE
SIS HQ.
VOCS
CLERK TYPES & RECORDS COMPLAINTS ON SIS-L LOG CARD
ROUTES TO SUPV. FOR ACCEPTANCE, REJECTION & ASSIGN PRIORITY
SUPERVISOR DECISION
SUSPENSE FILE SET-UP IF REQUIRED
ASSIGNED TO INVESTIGATOR FOR ACTION
INAPPROPRIATE REFERRAL RETURN TO SENDER OR REFER TO PROPER AGENCY
INVESTIGATION CONDUCTED & INVESTIGATIVE REPORT COMPLETED & RECOMMENDATION DRAFTED
CLERK TYPES INV. REPORT AND DRAFT RECOMMENDATION OBTAINS SIGNATURE ON INVESTIGATIVE REPORT
SUPERVISOR REVIEWS INVESTIGATIVE REPORT & RECOMMENDATION
CLERK REMOVES SUSPENSE IF ACTION IS COMPLETE
CLERK RETURNS COMPLETED ACTION & RECOMMENDATION TO VOCS OR SIS HQ.
INVESTIGATOR PRESENTS CASE TO THE PROSECUTOR
FILE ONE COMPLETE COPY OF CASE IF ACTION COMPLETE POST SIS LOG CARD & SEND COPY TO SIS HQ.
IF PROSECUTOR ACCEPTS CASE SUSPEND ONE COMPLETE COPY OF CASE PENDING FINAL RESULTS OF PROSECUTOR ACTION
TERMINAL
COMPLETED PROSECUTOR ACTION RETURNED TO ORIGINATOR
FILE ONE COMPLETE COPY OF CASE. POST SIS LOG CARD & SEND COPY TO SIS HQ.

Figure 16
OSI Field Office Caseflow

Incoming referrals are recorded on the OSI Log Card then given to a Supervisor who reviews the complaint. If the case is appropriate for OSI*, it is assigned a priority (usually based on dollar value) and sent to a special investigator or to a field office for action. The investigation is made (desk, field, or both) and a report filed that includes the investigator's recommended action. The supervisor reviews the report and recommendations and authorizes action -- referral back to originator, to prosecutor, or suspense pending outcome of other action. Cases referred for prosecution are tracked until the outcome is decided, then returned to the originator.

OSI is a designated Criminal Justice Agency, which has aided procurement of information from other criminal justice agencies. On the other hand, it has added to the clerical workload since records must be kept on incoming and outgoing documents. Investigators carry no weapons, have no badges, and do not have peace officer status. Only supervisors have subpoena power.**

A chronological listing of all Medicaid provider cases investigated by OSI since 1973 is given in Exhibit O.

In King County*** there is a special fraud unit. Called the "White Collar Crime" unit, it is not a part of OSI, but a part of the Attorney General's Office. It is the only unit of its kind in the state and its sole concern is what has been termed "economic crimes."* Some of its past work has involved Medicaid vendors**; this is expected to increase as the MMIS provides leads.

---

* Inappropriate cases are referred to another agency. Some cases may be refused because the dollar amount is small (under $250 in all counties but King where the limit is $500) or the case clearly does not involve fraud.

** In King County a Special Inquiry Judge is available to enforce compliance with an OSI-issued subpoena.

*** King County is the largest in Washington. Seattle is located here, and 40% of the state's AFDC residents reside there.

The White Collar Crime Unit consists of five attorneys, two investigators, and a legal intern. It handles its own investigations, though it may draw on the resources of OSI's Seattle regional office.*** The ultimate goal of the Unit is to prevent fraud; consequently care is taken to develop only solid cases that result in conviction, and to see that they are publicized.

3.4 DISPOSITION OF PROVIDER FRAUD****

DSHS may handle provider fraud administratively, legally, or both. ONHA has authority to revoke the license or certification of a nursing home or its administrator.***** Once revoked, a license may not be reissued. DSHS may also suspend or terminate a provider from participation in Title XIX.

---

* The idea for this Unit came from an attorney who became interested in the Economic Crime Project of the National District Attorney's Association. He now heads the Unit.

** A recently-concluded case involved an ambulance company.

*** The White Collar Crime Unit has collaborated with OSI on a seminar covering cost-reimbursement fraud.

**** In this section "fraud" is used to designate all cases that have been completely investigated, are suspected to be fraud, but have not been proved or disproved.

***** Although ONHA has the authority to delicense, it is not clear whether, practically speaking, it can be accomplished. In one instance it took 10 years to revoke a license because the proceeding was challenged in court as a denial of the means of livelihood.

Cases referred for criminal prosecution go first to the county prosecutor's office. Only if the case is refused will the US attorney become involved. No case will be referred unless the dollar amount involved is over $250 ($500 for King County). Medicaid provider cases are prosecuted under RCW9.54.010, grand larceny statute. The exact wording is given in Exhibit P.

Recent legislative changes have made prosecution easier. Clinical laboratories must now be licensed. It is now a misdemeanor for nursing homes to fail to place patient trust funds in a separate account. Because misdemeanor charges carry a lighter burden of proof (it is not necessary to prove intent, for example) it is easier to get a conviction.

Although formal OSI referral of a case is not made until the case is ready to be prosecuted, informal conferences may be held during the course of an investigation. At the State level, the Assistant Attorney General's Division provides legal advice to the OSI State office.

Once accepted, a case will be fully prosecuted; that is, restitution will not be accepted in lieu of prosecution. Whether or not a conviction is obtained, a civil remedy seeking restitution of funds may be pursued. Restitution may be handled by withholding from future claims or by direct payment to DSHS.

3.5 ASSESSMENT OF PROVIDER FRAUD CONTROL PROGRAM

It is premature to assess Washington's Medicaid provider fraud control program. DSHS's methods of dealing with provider fraud will undergo many changes as the MMIS begins to generate claims-based information, and provider fraud control should become increasingly better. It is appropriate to point out certain features of the existing fraud control program that will be enhanced by the MMIS.

OSI will probably be most affected by the MMIS. The volume of referrals from claims processing can be expected to rise dramatically. Even though many of these referrals will be open-and-shut cases requiring very little investigation, others will take time to develop. OSI seems to be prepared for this increased workload. Administrative procedures and investigative techniques have been established and function smoothly. Several investigators are being trained as specialists in provider fraud investigation. OSI's assistant director recognizes the need to contact physician specialists to work under contract as medical consultants. The attitude of OSI is changing from concern with AFDC recipient fraud to concern with Medicaid provider fraud.

Program limitations on amount, duration and scope, the need for prior authorization, and documentation to support certain claims all help reduce the amount of provider fraud. DSHS has undertaken control of institutional fraud by requiring disclosure of wholly-owned businesses serving each other and by rewriting the Washington Administrative Code to tighten regulations governing nursing homes. Dedication of one section of the Office of Operations Review to developing and implementing a cost-based reimbursement system for nursing homes will benefit fraud control in this easily-abused area.

4 CONTROL OF MEDICAID RECIPIENT FRAUD

In Washington Medicaid recipient fraud is not considered by itself, but only as a corollary to AFDC recipient fraud. There is no administrative structure dedicated to Medicaid recipient fraud control; the AFDC fraud control structure is used instead. Consequently the description below of Medicaid recipient fraud control is actually the AFDC control process as it pertains to Medicaid.

4.1 PREVENTION AND DETECTION OF RECIPIENT FRAUD

DSHS emphasizes prevention as the key to recipient fraud control. Efforts are directed toward preventing ineligibles from ever being placed on the welfare rolls.

Applicants for assistance must complete four forms: the Application for Assistance, a Medical Supplement, a Statement of Employment and Health, and a Personal Property Supplement (see Exhibits R, S, T, U). Applications may be obtained from any local DSHS office, at hospitals, and other public places.

Once completed, the applications are reviewed by an intake worker. Statements are verified by applicant-supplied supporting documentation (see Exhibit V) and by computer tie-in to a main eligibility data bank.* No verification is attempted for negative responses.

Each applicant is interviewed by an intake worker. If the worker notices any irregularities or is suspicious of any statements, the case may be referred to the VOCS Unit for investigation.

VOCS (Verification Overpayment Control System) is a screening process used in all local DSHS offices to verify eligibility. The VOCS unit is staffed by Financial Service Technician III (FST-3), the most experienced FST personnel. Cases referred to VOCS are logged in on a VOCS-1 form and a 5x8 card. The VOCS Unit has 8 days to investigate the case and respond to the originator.

---

* Besides its own eligibility data, DSHS exchanges data with several state and federal agencies, thereby gaining access to information on earned income, social security benefits, unemployment compensation, etc.

Investigations include both desk and field; in addition, the client may be called in for an interview. VOCS will keep a case to the point where it "cannot disprove fraud"; then cases involving more than $250 ($500 in King County) will be referred to OSI for their investigation. Cases under the dollar limit for referral, or not fraud, will be referred back to the originator.

VOCS may also get referrals for clients already receiving aid. The same case procedures are followed, except cases under the dollar limit or not fraudulent are referred for restitution.

DSHS compiles a "Professional Patient" list which is circulated to local welfare offices. All services for patients on the list must have prior authorization from the local medical consultant.

DSHS performs a quality control check on medicaid eligibility determinations. A statistically-valid sample of recipient applications is selected and sorted by geographic area. The recipient names are sent to field units where reviewers are assigned to the case. They conduct a field investigation to verify the accuracy of the original determination, then file a narrative report of findings. If a reviewer notes any indications of fraud, it is reported to the local office.

Recipients who disagree with eligibility determinations may request a fair hearing. DSHS has a state office and four field offices so that hearings can be held in a recipient's geographic area.

4.2 INVESTIGATION AND DISPOSITION OF RECIPIENT FRAUD

Investigation of recipient fraud may be undertaken by either the VOCS unit or OSI. Investigative techniques are basically the same for recipients as for providers.

Recipients convicted of or admitting fraud must make restitution equal to 125% of the overpayment. The additional 25% is a penalty assessment. Restitution payments may be deducted from grants to a maximum of 10% each month.

Restitution is handled by the Reimbursements Section. Recovery must be initiated within 6 years of the occurrence of overpayment or termination of welfare. In FY 75 the Reimbursement Section recovered $159,624 in public assistance overpayments. It is not known how much of this total was recovery for medical benefits.

Third-party medical liability is the responsibility of the Office of Support Enforcement. It may seek recovery of funeral and medical expenses from liable third parties. At present DSHS relies on recipients or physicians to indicate third party liability, either on the assistance application form or on the provider claim form.

DSHS assumes no responsibility for medical payment on behalf of a recipient whose condition is caused by negligence or wrong-doing of another person. If DSHS does elect to pay for medical care under these conditions, it gains the legal right to recover such payments ahead of the recipient's right of recovery. The recovery is handled by Support Enforcement.

In FY 75, the Office of Support Enforcement increased its total collections by 24% over the previous fiscal year. A breakdown by programs is given below:

Child Support Collections	
- Public Assistance Cases	$10,586,172
- Non-Assistance Cases	3,602,504
Medical Third-Party Collections	2,664,415
Funeral Collections	270,094

5 CONTROL OF FRAUD COMMITTED BY MEDICAID AGENCY PERSONNEL

Any allegation of employee msiconduct is by nature a sensitive issue. It requires careful handling by as few people as possible.

All allegations against DSHS employees are referred to OSI for investigation. From August, 1973 to May 1976, OSI conducted 76 investigations of employee misconduct, most involving welfare fraud. None of the investigations involved misuse of medical services. A chronological case listing, including resolution, is given in Exhibit Q.

There is a DSHS administrative unit whose activities might indirectly result in detection of agency fraud. The Office of Operation Review's Performance Audit Section is responsible for internal management audits. Its goal is to provide management with current information on how well a unit is functioning. All DSHS units, including public assistance offices, are candidates for review.

Reviews cover the present organization and management of the unit (including existing management controls), fiscal matters, and a special kind of program evaluation designed to answer the question, "Under present design, can this unit deliver mandated services?" A typical review lasts 10-15 days. During that time a management expert will review the unit's organization, planning, use of time, standard operating procedures, staffing, management controls, staff meetings, and communications. An accountant reviews fiscal practices and controls on money and negotiable items. A welfare program specialist reviews eligibility and grant determinations. A social services program specialist determines the adequacy of delivery of social services to clients in all programs. The audit team leader contacts community agencies such as employment security, juvenile probation, adult parole, etc. After on-site work, the audit team returns to its home office and prepares a report of its findings and recommendations.

Though its stated purpose is to improve unit operations through better management, it would seem that the activities of the Performance Audit Section would also serve as a good agency fraud detection tool.

6 BEST PRACTICES FOR CONTROLLING MEDICAID FRAUD

This section describes effective techniques currently being used in Washington to control Medicaid fraud. Though DSHS is still in transition from manual to automated claims processing, and is consequently revising some of its fraud control mechanisms, other noteworthy features remain unchanged. They are discussed here as "best practices."

The best practices in this section are grouped by function: fraud prevention, detection, investigation, or disposition. Activities within each function are separated into provider, recipient, and agency fraud control.

6.1 BEST PRACTICES FOR PREVENTING FRAUD

DSHS devotes much of its resources to preventing Medicaid fraud. An oft-expressed sentiment is that the only real way to control fraud is to prevent its occurrence.

DSHS is now using preventive measures common to a manual system -- limitations on amount, duration and scope of services, requirement for prior authorization of certain easily-abused or expensive services, requirement for documentation to support certain types of claims. The effectiveness of these measures will be enhanced by automated claims processing, since it can rapidly separate routine claims from those needing special attention. Special claims can be sorted and examined before payment for patterns of overutilization, abuse, and potential fraud to a degree not possible under a manual system.

The Office of Operations Review makes an important contribution to fraud prevention. By dedicating its Cost-Reimbursement Section to developing and implementing the cost-based reimbursement system for nursing homes, efforts are concentrated on controlling this easily-abused system. Substantial additions to the Washington Administrative code strengthen the statuatory ability of DSHS to control fraud. The new cost-reimbursement manual promotes uniform application of standards during fiscal audit, as well as specifying the financial responsibilities of nursing homes.

DSHS personnel have established professional contacts in other states and nationally. This has resulted in informal data exchange on successful fraud control measures and on individual providers who are moving from state to state.

Publicity may assume a larger role in provider fraud prevention, especially as the activities of the "White Collar Crime" Unit intensify. The idea of regarding economic crimes as serious infractions of the law will effect the attitude toward pursuing Medicaid provider fraud.

Though the legality of a "professional patient list" has not been established, DSHS keeps one. All services for anyone on the list require prior authorization.

6.2 BEST PRACTICES FOR DETECTING FRAUD

The switch from manual to automated claims processing will greatly effect fraud detection. Once an adequate paid-claims data base has been developed, the MMIS will begin to produce provider and recipient utilization profiles. These can be screened and analyzed for patterns of quesionable treatment or billing, or outright fraud.

The Office of Operations Review has two sections contributing to fraud detection. Auditors from the Fiscal Audit Section may note on a worksheet any instances of possible fraud that are detected during routine, institutional financial audit. (Auditors from the Office of Nursing Home Affairs may make the same notations.) Auditors from the Performance Audit Section may detect fraud committed by agency personnel, since a performance audit examines management and operational practices.

The requirement that nursing home suppliers reveal the nature of their business relationship with the institutions they serve acts as a fraud detection device. DSHS may be alerted to carefully examine charges claimed by institutions for services purchased from wholly-owned subsidiaries.

6.3 BEST PRACTICES FOR FRAUD INVESTIGATION

The Office of Special Investigations is a well-organized, professional unit. Since OSI's Director reports directly to the Secretary of DSHS, the likelihood is small that political pressure can be applied to alter the course of an investigation. Policy and direction-setting decisions are made at the State office level; case referrals flow to regional offices after state office screening. OSI has qualified as a Criminal Justice agency, thereby easing data acquisition.

Investigators are recruited from professions closely related to OSI-type activities, minimizing the need for special training. Investigators work with a comprehensive Operating Manual covering all job activities. Special resource personnel are available on request from the state office.

The "White Collar Crime" Unit, which specializes in economic crimes, can be expected to develop expertise in investigating and prosecuting provider fraud. The VOCS (Verification Overpayment Control System) already has such expertise in recipient fraud investigations. Having social service workers trained as VOCS investigators adds a useful dimension to DSHS's capability.

OSI is very active in investigating referrals of employee misconduct. Investigations are handled discreetly, but take place on an average of 3-4 per month. A special investigator is often assigned to employee cases.

6.4 BEST PRACTICES FOR DISPOSITION OF FRAUD

Gaining a fraud conviction is aided by several measures: statutes under which prosecutions may be brought have been expanded or revised to include some misdemeanor as well as felony provisions. Since the burden of proof is lighter for misdemeanors, more successful prosecutions may be brought. Each OSI office may request legal advice from the Assistant Attorney General's office during the course of an investigation. This assures that no critical element will be missing when it is time to refer a case for prosecution.

Restitution of improperly-paid funds may be secured from recipients at the rate of 125% of the actual overpayment. There is some thought of extending this penalty provision to providers, too.

DSHS does not assume responsibility for medical payments on behalf of a patient whose injuries are due to the deliberate or negligent actions of another person. If DSHS does elect to pay for services it reserves the right to recover such payments ahead of the injured party's right of recovery.

6.4.1 RECORD KEEPING SYSTEM

OSI employs one individual on a full time basis to monitor the outcomes of all cases through any court action. A competent record keeping system can be of value in many ways:

- It provides the investigator with feedback as to the outcome of each case;
- It serves as a summary sheet for management in determining the kinds and frequency of fraud cases that have been investigated and which ones have actually been prosecuted. Such information may suggest shifts in the ways certain cases are approached; and
- It ensures that cases do not "fall through the cracks" when they are referred to the regional offices and county prosecutors

6.5 BEST PRACTICES FOR PROVIDER RELATIONS

The Remittance Advice sheets described earlier in this report were instituted at the time the department was shifting from a manual to an automated claims processing system. It was quite wisely anticipated that the initial transition would cause delays in payments and result in complaints from physicians and submission of duplicate bills. The advice sheets were designed to prevent this from happening, by giving the provider an update on the status of his bills.

The concept, however, continues to have valid application for Washington and possibly other states. Many states have had problems with duplicate billings which were believed to be fradulent. The provider, however, would counter that a second bill was submitted "in error" since payment had not been received. The Remittance Advice sheets make such claims by the provider improbable, since the sheet tells the provider the status of each claim submitted. The Remittance Advice sheets, therefore, simultaneously serve to prevent error, and to prevent the provider from later excusing fraud as error.

APPENDIX

Documents Collected

Washington State, Fall 1975 and Spring 1976, Information Services Division, Office of Planning and Fiscal Management.

"State of Washington Budget," 1975-77 Biennium, submitted December 1974.

"State of Washington Supplemental Budget," 1975-77 Biennium, submitted January 1976.

State of Washington Pocket Data Book 1975, Office of Program Planning and Fiscal Management, January 1976.

"An Explanation of Medicaid (Title XIX) of the Social Security Act: Medical Assistance in Washington State," State of Washington Department of Social and Health Services, January 1976.

Washington State Government Organization charts, July 1974-July 1976.

"Information packet for Nursing Home Administrators," Office of Operation Review, Management and Budget Division, DSHS, September 1975.

Provider manuals: Physician's Manual (Office of Medical Assistance, Health Services Division, Januaty 1976); Drug Handbook and Index (Office of Medical Assistance, Health Services Division, January 1976) and memoranda.

Billing instructions and forms: hospital inpatient and outpatient, nursing home; congregate care; physican; medical vendor; pharmacy.

MMIS Monthly Status Report, July 1976 and sample output.

Nursing Home Cost Reimbursement Quarterly and Annual Reports

WAC Chapter 388-96, Nursing Home Accounting and Reimbursement System.

Remittance Advice and Explanation.

Manual for Nursing Home Administrators Concerning Patient Trust Fund Accounts (Office of Operations Review, Management and Budget Division).

DSHS Laboratory Review Guide and Questionnaire.

Explanation of Medicaid Benefits (EOMB) form and cover memo.

Office of Special Investigations Operating Manual.

SIS (OSI) Log Card.

Chronological Record of Medicaid Fraud and Abuse Investigations, 1974-1976.

Chronological Record of Allegations of Employee Misconduct, August 1973-May 1976.

Application for Assistance, Medical Supplement, Statement of Employment and Health, Personal Property Supplement.

Verification Requirements.

EXHIBITS

EXHIBIT A

GENERAL MEDICAL ASSISTANCE

Category Description

The general medical assistance category includes Medicaid (Title XIX) payments for medical care and services provided to money grant recipients and to medically needy persons who do not have the resources to meet the costs of medical care and who qualify for public assistance except for excess income and resources. During the 1973-75 Biennium, the medical care provided to these two groups of individuals was matched at 53.13 percent by the federal government. For the 1975-77 Biennium, the Department of Health, Education and Welfare has increased this federal matching percentage to 53.72 percent for the state. Medical care and services provided to recipients of general assistance who cannot be categorically related to a federal grant program, and to medical indigents financed entirely by the state. Medical indigents generally are persons between the age of 21 and 65 years of age who are neither blind nor disabled as legally defined, and whose income, credit, potential earnings or medical resources are insufficient to meet the costs of necessary medical resources.

Budget Justification

The total recommended budget of $405,435,452 includes an increase of $120,826,304 to maintain current staff and level of services. This includes $48,274,663 to maintain a new nursing home cost reimbursement system implemented July 1974. Other increases are $26,903,787 for other medical vendors, excluding hospitals, $2,133,560 for expansion of early and periodic screening, diagnosis, and treatment of children, and $9,093,274 for workload increases. Vendor rate increases include 7.4 percent effective July 1, 1975 and an additional 7.2 percent effective July 1, 1976 for inflationary costs.

Reductions in the budget from cost savings measures are assumed as follows: quality control for the Medically Needy ($4,049,001); quality control in General Assistance and review of Foster Care caseload ($502,625); implementation of a mechanized utilization review system ($1,200,000); general tightening of utilization controls ($11,737,405); reduction in lengths of hospital stay ($4,834,364); intensified screening of nursing home patients ($20,667,310); nursing home drugs on a bid basis and some tranquilizers on an exception basis only ($3,122,123); glasses on a bid basis ($157,200); and a reduction of 400 General Assistance cases ($460,000).

The resulting net increase in this budget amounts to $112,226,897. The increase in the federal matching percentage will save an estimated $2,225,770 in state funds.

Expenditure Detail

	1972-73 Actual	1973-74 Actual	1974-75 Estimated	1975-76 Proposed	1976-77 Proposed
Contributions, Grants, Subsidies	118,897,953	140,649,110	152,559,445	190,202,466	215,232,986
ANNUAL TOTAL	118,897,953	140,649,110	152,559,445	190,202,466	215,232,986
FISCAL YEAR 1971-72	109,992,902				
BIENNIUM TOTAL	228,890,855	293,208,555		405,435,452	

Source of Funds

	1972-73 Actual	1973-74 Actual	1974-75 Estimated	1975-76 Proposed	1976-77 Proposed
General Fund--State	58,949,770	71,957,724	79,005,480	95,171,190	107,597,685
General Fund--Federal	56,588,001	67,992,152	72,406,604	95,031,276	107,635,301
General Fund--Federal--Unanticipated	....	699,234	1,147,361	....	....
Contingent Receipts Fund--Federal--Unanticipated	3,360,182	....	....	....	....
ANNUAL TOTAL	118,897,953	140,649,110	152,559,445	190,202,466	215,232,986

EXHIBIT B

PREVENTION OF BLINDNESS ASSISTANCE

Category Description

The objective of the prevention of blindness assistance category is to encourage prompt specialized medical eye care for conditions in which sight is endangered or in which sight can be restored, and to assist in the payments for costs of care when necessary. Services are provided to both adults and children. The cost of the care provided to those individuals eligible under Title XIX is matched by the federal government; the costs of care provided to individuals who are not eligible for Title XIX benefits are covered by state funds.

Budget Justification

The recommended budget for this category represents an increase of $180,345 and a decrease of 0.5 FTE staff years from projected expenditures for the current biennium. A total increase of $640,330 will maintain the current staff and level of services. The Prevention of Blindness medical expenditures are projected to decrease by $516,693, offset by the effects of inflation on vendor payments of $56,708.

Category Employment

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Proposed*	*1976-77 Proposed*
FTE Staff Years	2.6	3.1	2.6	2.6	2.6
Average FTE Staff Year Costs	9,579	8,918	10,612	10,879	10,970

Expenditure Detail

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Estimated*	*1976-77 Estimated*
Salaries and Wages	24,906	27,647	27,592	28,286	28,524
Personal Service Contracts	63	110	224	....	....
Goods and Services	2,990	3,106	3,532	5,248	5,706
Travel	128	274	322	645	645
Equipment	1,032	2,185	1,615	....	....
Employee Benefits	2,785	4,081	4,594	4,759	4,791
Contributions, Grants, Subsidies	554,023	447,143	1,126,585	845,433	905,318
ANNUAL TOTAL	585,927	484,546	1,164,464	884,371	944,984
FISCAL YEAR 1971-72	343,100				
BIENNIUM TOTAL	929,027	1,649,010		1,829,355	

Source of Funds

	1972-73	*1973-74*	*1974-75*	*1975-76*	*1976-77*
General Fund--State	380,943	247,412	595,962	447,848	478,516
General Fund—Federal	134,564	237,134	568,502	436,523	466,468
Contingent Receipts Fund—Federal—Unanticipated	70,420	....	....	....	....
ANNUAL TOTAL	585,927	484,546	1,164,464	884,371	944,984

EXHIBIT C

ELIGIBILITY DETERMINATION

Category Description

The eligibility determination category includes the staff costs of prevention of blindness assistance and staff costs of Welfare Eligibility Examiners and their first-line supervisors who determine financial eligibility for applicants of medical only assistance.

Budget Justification

The recommended budget for the Eligibility Determination Category represent a decrease of $127,293 and 55.8 FTE staff years from projected expenditures for the current biennium. An increase of $561,065 and 10.3 FTE staff years is to maintain the current staff and level of services; $8.972 and 0.8 FTE staff years are requested for workload change. A savings of $697,330 and 66.9 FTE staff years is anticipated as a result of the Department's Workload Planning and Control activity for welfare eligibility examiners.

	1972-73 Actual	1973-74 Actual	1974-75 Estimated	1975-76 Proposed	1976-77 Proposed
Category Employment					
FTE Staff Years	253.9	260.9	264.4	235.0	234.5
Average FTE Staff Year Costs	7,955	8,546	9,157	9,421	9,682
Expenditure Detail					
Salaries and Wages	2,019,888	2,229,894	2,421,128	2,213,982	2,270,651
Travel	5,234	6,005	6,921	16,875	16,840
Employee Benefits	243,334	356,346	424,961	396,270	403,344
Annual Total	2,268,456	2,592,245	2,853,010	2,627,127	2,690,835
Fiscal Year 1971-72	2,074,991				
Biennium Total	4,343,447	5,445,255		5,317,962	
Source of Funds					
General Fund—State	1,134,228	1,322,032	1,483,565	1,340,004	1,373,590
General Fund—Federal	1,134,228	1,270,213	1,369,445	1,287,123	1,317,245
Annual Total	2,268,456	2,592,245	2,853,010	2,627,127	2,690,835

EXHIBIT D

PROGRAM SUPPORT

Category Description

This category contains the funding for all administrative and indirect costs where staff efforts benefit more than one program category, except for Eligibility Determination. Included are prorata costs of local office administrators, clerical workers and second-line supervisors, and state office program development staff whose duties cross program category lines. This category includes the personnel service charge from the State Personnel Department and communications charges. All expenses associated with the operation and maintenance of buildings, such as rental, janitorial services and office supplies, are included in this category.

Budget Justification

The recommended budget for the Program Support category represents an increase of $8,610,932 and 113.8 FTE staff years over the projected expenditures for the current biennium. Of this increase, $1,058,585 and a decrease of 9.4 FTE staff years will maintain the current staffs and level of services; $952,107 and 71.9 FTE staff years are requested for workload changes and $1,030,881 and 77.2 FTE staff years for added services.

Administrative improvements included in this category will add $5,853,000 for a mechanized Medicaid (Title XIX) claims processing system. Savings of $283,641 and 25.9 FTE staff years are anticipated as a result of the proposed implementation of the Department's Workload Planning and Control activity.

Category Employment

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Proposed*	*1976-77 Proposed*
FTE Staff Years	179.1	201.2	199.8	257.7	257.1
Average FTE Staff Year Costs	10,031	10,260	11,074	10,646	10,844

Expenditure Detail

Salaries and Wages	1,796,666	2,064,413	2,212,774	2,743,672	2,788,092
Personal Service Contracts	3,347	25,283	6,523	2,398,306	3,043,306
Goods and Services	493,378	660,334	666,040	1,302,476	1,365,700
Travel	56,836	54,414	69,458	110,991	109,715
Equipment	23,955	17,147	17,857	111,030	9,846
Employee Benefits	171,663	350,258	349,737	650,136	471,900
ANNUAL TOTAL	2,545,845	3,171,849	3,322,389	7,316,611	7,788,559
FISCAL YEAR 1971-72	2,322,044				
BIENNIUM TOTAL	4,867,889	6,494,238		15,105,170	

Source of Funds

General Fund - State	1,002,786	1,412,746	1,423,000	2,669,296	2,746,199
General Fund - Federal	1,188,888	1,759,103	1,899,389	4,647,315	5,042,360
Contingent Receipts Fund - Federal Unanticipated	354,171	....	....	....	......
ANNUAL TOTAL	2,545,845	3,171,849	3,322,389	7,316,611	7,788,559

EXHIBIT E

Budget Request for
Administrative Support Services
Aiding Medical Assistance Program

SUMMARY

Request	$57,733,878
Net Change from Current Biennium	$14,648,454 Increase
Percent Change from Current Biennium	34.0% Increase

Program Description

The goal of the program is to provide effective planning, management, control, and evaluation of the operations of the Department of Social and Health services through eight functionally distinct categories: General Administration, Personnel, Information Systems, Collections and Reimbursements, Operations and Fiscal Audit, Fiscal Services, Special Projects, and Other Supporting Services.

Budget Justification

An increase of $14,648,454 and 677.3 FTE staff years over the 1973-75 level of expenditure is recommended for the Administration and Supporting Services program. Detailed information on increases and decreases is found below with each category.

OPERATING BUDGET—SUMMARY BY OBJECT

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Proposed*	*1976-77 Proposed*
Salaries and Wages	10,547,920	11,461,352	13,529,585	16,520,056	17,456,108
Personal Service Contracts	1,291,098	714,262	2,893,979	1,828,072	1,874,416
Goods and Services	6,061,604	4,581,881	4,592,125	6,216,935	6,139,923
Travel	433,106	396,351	544,463	765,673	759,265
Equipment	1,129,296	164,419	210,174	261,388	91,994
Employee Benefits	1,210,970	1,784,449	2,294,652	3,048,460	3,188,387
Interagency Reimbursement	(648,753)	(53,468)	(28,800)	(212,466)	(204,333)
ANNUAL TOTAL	20,025,241	19,049,246	24,036,178	28,428,118	29,305,760

OPERATING BUDGET—CATEGORY SUMMARY

General Administration	3,222,810	3,510,361	4,503,303	4,051,201	4,212,611
Personnel	1,954,139	1,290,739	1,669,579	1,469,622	1,563,066
Information System	4,070,260	3,977,470	4,303,713	5,899,538	5,959,594
Collections and Reimbursements	1,831,399	2,398,120	3,041,515	3,915,459	4,193,153
Operations and Fiscal Audit Services	1,344,117	1,655,927	2,041,677	3,019,915	3,230,176
Fiscal Services	2,540,315	2,892,182	3,259,066	3,651,948	3,689,529
Special Projects	2,940,111	965,903	2,534,525	2,051,988	2,061,556
Program Support	2,122,090	2,358,544	2,682,800	4,368,397	4,369,065
ANNUAL TOTAL	20,025,241	19,049,246	24,036,178	28,428,118	29,305,760
FISCAL YEAR 1971-72	14,668,745				
BIENNIUM TOTAL	34,693,986	43,085,424		57,733,878	

PROGRAM EMPLOYMENT

FTE Staff Years	1,204.3	1,096.4	1,213.2	1,480.1	1,506.8
Average FTE Staff Year Costs	8,758	10,453	11,151	11,161	11,584

SOURCE OF FUNDS

General Fund State	7,702,080	10,076,952	12,751,004	16,221,320	16,755,185
General Fund -Federal	8,038,091	8,958,794	11,282,669	12,206,798	12,550,575
General Fund -Local	....	13,500	2,505	....	....
Contingent Receipts Fund -Federal -Unanticipated	4,230,665	....	....	....	....
Contingent Receipts Fund -State- Unanticipated	54,405	....	....	....	....
ANNUAL TOTAL	20,025,241	19,049,246	24,036,178	28,428,118	29,305,760

Exhibit E cont.

BY SUB-CATEGORY

GENERAL ADMINISTRATION

Category Description

This category is composed of the Office of the Secretary, legal services, planning and research, and service delivery administration. The office of the Secretary is the top-level review and policy-making entity for the Department. The legal services division, headed by the senior assistant attorney general, represents the Department in legal proceedings, provides legal counsel, reviews present and proposed legislation and Departmental policy. The planning and research division makes institutional population projections and public assistance caseload projections, and performs program and fiscal analyses of proposed legislation and departmental programs. Service delivery administration includes the activities of the headquarters service delivery staff and the offices of the six regional administrators.

Budget Justification

The recommended budget for the General Administration category provides an increase of $250,148 and 13.8 FTE staff years over the 1973-75 level of expenditure to meet inflationary cost growth in support of current staff and level of service.

Category Employment

	1972-73 Actual	1973-74 Actual	1974-75 Estimated	1975-76 Proposed	1976-77 Proposed
FTE Staff Years	133.8	147.7	174.5	167.5	167.5
Average FTE Staff Year Costs	13,435	13,581	14,111	14,521	15,105

Expenditure Detail

Salaries and Wages	1,797,696	1,997,838	2,462,537	2,432,302	2.530,219
Personal Services Contracts	635,033	123,071	665,946	110,001	109,999
Goods and Services	922,830	954,301	844,124	974.698	1,020,366
Travel	149,200	143,728	146,444	175,310	178,569
Equipment	59,069	7,716	14,656	15,283	7,089
Employee Benefits	187,919	290,707	381,596	404.375	414,369
Interagency Reimbursement	(528,937)	(7,000)	(12,000)	(60,768)	(48,000)
ANNUAL TOTAL	3,222,810	3,510,361	4,503,303	4,051,201	4,212,611
FISCAL YEAR 1971-72	2,645,725				
BIENNIUM TOTAL	5,868,535	8,013,664		8,263,812	

Source of Funds

General Fund—State	1,518,771	2,072,507	2,701,985	2,491,489	2.590,756
General Fund--Federal	1,393,455	1,437,854	1,801,318	1,559,712	1,621,855
Contingent Receipts Fund--Federal--Unanticipated	310,584	....	....	....	....
ANNUAL TOTAL	3,222,810	3,510,361	4,503,303	4,051,201	4.212,611

PERSONNEL

Category Description

The personnel category of this program is concerned with the development, implementation, and operation of the personnel system and employee training program for the Department. The category has two components, personnel services and staff training. Personnel services include employee services, compensation planning, manpower planning and employment and recruiting functions. Staff training provides the technical and managerial training to provide qualified staff for the Department's programs.

Budget Justification

The recommended budget for this category provides an increase of $77,370 and 1.9 FTE staff years over the 1973-75 level of expenditure to meet inflationary cost growth in support of current staff and level of service.

Category Employment

	1972-73 Actual	1973-74 Actual	1974-75 Estimated	1975-76 Proposed	1976-77 Proposed
FTE Staff Years	100.0	73.1	75.0	75.0	75.0
Average FTE Staff Year Costs	11,138	13,071	13,797	13,072	13,957

Exhibit E cont.

PERSONNEL

Category Description

The personnel category of this program is concerned with the development, implementation, and operation of the personnel system and employee training program for the Department. The category has two components, personnel services and staff training. Personnel services include employee services, compensation planning, manpower planning, and employment and recruiting functions. Staff training provides the technical and managerial training to provide qualified staff for the Department's programs.

Budget Justification

The recommended budget for this category provides an increase of $77,370 and 1.9 FTE staff years over the 1973-75 level of expenditure to meet inflationary cost growth in support of current staff and level of service.

Category Employment

	1972-73 Actual	1973-74 Actual	1974-75 Estimated	1975-76 Proposed	1976-77 Proposed
FTE Staff Years	100.0	73.1	75.0	75.0	75.0
Average FTE Staff Year Costs	11,138	13,071	13,797	13,072	13,957

Expenditure Detail

	1972-73 Actual	1973-74 Actual	1974-75 Estimated	1975-76 Proposed	1976-77 Proposed
Salaries and Wages	1,113,863	955,506	1,034,798	980,438	1,046,825
Personal Service Contracts	196,162	69,641	31,492	33,200	33.200
Goods and Services	415,394	84,201	382,909	222,089	260.828
Travel	93,085	46,319	52,578	55,009	45,628
Equipment	12,125	3,825	1,714	5,539	....
Employee Benefits	123,510	131,247	166,088	173.347	181,585
ANNUAL TOTAL	1,954,139	1,290,739	1,669,579	1,469,622	1,568,066
FISCAL YEAR 1971-72	1,916,771				
BIENNIUM TOTAL	3,870,910	2,960,318		3.037,688	

Source of Funds

	1972-73 Actual	1973-74 Actual	1974-75 Estimated	1975-76 Proposed	1976-77 Proposed
General Fund—State	657,618	715,961	1,064,824	903,818	964,361
General Fund—Federal	1,066,334	574,778	604,755	565.804	603.705
Contingent Receipts Fund—Federal—Unanticipated	230,187	....	....	....	....
ANNUAL TOTAL	1,954,139	1,290,739	1,669,579	1,469,622	1,568,066

Exhibit E cont.

INFORMATION SYSTEMS

Category Description

The Information Systems category consists of the data processing operations necessary to support all of the Department's programs and the development of information systems for all departmental activities.

Budget Justification

The total increase for this category is $3,577,999 and 102.9 FTE staff years of which $1,292,175 and 12.9 FTE staff years are needed to maintain the current staff and level of service. Fifteen positions (30.0 FTE staff years and $343,774) are recommended to meet workload increases and thirty positions (60.0 FTE staff years and $1,124,147) are recommended to upgrade the Department's information systems prior to consolidation of those systems with other state agencies. A total of $319,373 is recommended for expansion of the Public Assistance terminal system and $85,000 for professional updating of staff. In addition, the administrative costs for the monthly reporting of medical benefits and the twice-monthly grant payments in the public assistance program are included at $413,530.

Category Employment

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Proposed*	*1976-77 Proposed*
FTE Staff Years	226.3	242.1	255.0	295.2	304.8
Average FTE Staff Year Costs	8,925	9,794	10,138	10,380	10,720

Expenditure Detail

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Proposed*	*1976-77 Proposed*
Salaries and Wages	2,019,847	2,371,248	2,585,277	3,064,288	3,270,204
Personal Service Contracts	229,958	96,061	....	55,000	55,000
Goods and Services	1,114,821	1,123,244	1,224,096	2,108,729	1,971,005
Travel	9,400	5,859	5,475	48,299	49,133
Equipment	575,882	18,070	53,995	59,679	11,572
Employee Benefits	237,664	377,595	451,670	583,069	622,156
Interagency Reimbursement	(117,312)	(14,607)	(16,800)	(19,476)	(19,476)
ANNUAL TOTAL	4,070,260	3,977,470	4,303,713	5,899,588	5,959,594
FISCAL YEAR 1971-72	3,449,945				
BIENNIUM TOTAL	7,520,205	8,281,183		11,859,182	

Source of Funds

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Estimated*	*1976-77 Estimated*
General Fund—State	2,063,290	2,395,112	2,582,228	3,628,247	3,665,151
General Fund—Federal	1,646,385	1,582,358	1,721,485	2,271,341	2,294,443
Contingent Receipts Fund—Federal—Unanticipated	360,585	....	....	....	....
ANNUAL TOTAL	4,070,260	3,977,470	4,303,713	5,899,588	5,959,594

Exhibit E cont.

COLLECTIONS AND REIMBURSEMENTS

Category Description

The category includes activities necessary for the collection of child-support payments, monies from institutional residents able to pay, and reimbursements for overpayments and improper payments in public assistance grants. The central accounts for these collections and reimbursements are included within this category.

Budget Justification

A total increase of $2,673,977 and 123.7 FTE staff years is recommended for this category. Of this total, $1,643,153 and 42.6 FTE staff years are required to maintain the current staff and level of service. This staff level was approved by the 1974 Legislature. New staff are recommended at 28.5 FTE staff years ($358,673), to meet projected workload increases in the non-assistance support collections and at 52.6 FTE staff years to increase collections, thereby generating additional revenue for the General Fund.

Category Employment

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Proposed*	*1976-77 Proposed*
FTE Staff Years	156.4	201.4	244.0	279.6	289.5
Average FTE Staff Year Costs	8,182	8,890	9,280	9,300	9,576

Expenditure Detail

	1972-73	1973-74	1974-75	1975-76	1976-77
Salaries and Wages	1,279,708	1,790,574	2,264,342	2,600,513	2,772,276
Personal Service Contracts	213	643	....	....	....
Goods and Services	302,593	242,407	260,457	662,766	785,708
Travel	42,152	43,238	50,813	78,339	77,774
Equipment	53,269	28,543	44,388	46,909	8,185
Employee Benefits	155,165	292,715	421,515	526,932	554,210
Interagency Reimbursement	(1,701)	....	....	....	....
ANNUAL TOTAL	1,831,399	2,398,120	3,041,515	3,915,459	4,198,153
FISCAL YEAR 1971-72	2,022,535				
BIENNIUM TOTAL	3,853,934	5,439,635		8,113,612	

Source of Funds

	1972-73	1973-74	1974-75	1975-76	1976-77
General Fund—State	791,654	1,316,475	1,822,076	2,408,008	2,581,865
General Fund—Federal	850,147	1,081,645	1,219,439	1,507,451	1,616,288
Contingent Receipts Fund—Federal—Unanticipated	189,598	....	....	....	....
ANNUAL TOTAL	1,831,399	2,398,120	3,041,515	3,915,459	4,198,153

Exhibit E cont.

OPERATIONS AND FISCAL AUDIT SERVICES

Category Description

The category includes the review and evaluation of management and fiscal operation control for the Department, the Special Investigations unit and the Fair Hearings Section. This category monitors the Department's compliance with federal laws and regulations and audits the Department's and vendors' compliance with internal and federal fiscal requirements and procedures. Operations review teams perform management analyses of various Departmental programs and organizational units, recommending more efficient organization structures, different staffing patterns and other management improvements. The special investigations unit investigates alleged recipient or employee fraud with regard to the payment of benefits. Reinstatement appeals hearings are provided through the Fair Hearings Section for persons declared ineligible for services or benefits from departmental programs.

Budget Justification

The total increase recommended for this category is $2,552,487 and 134.3 FTE staff years. Of this amount, $1,307,118 and 64.3 FTE staff years are required to maintain the current staff and level of service. This staff level was approved by the 1974 Legislature.

Nine new positions (18.0 FTE staff years, $272,466) are recommended to meet projected workload in the fraud investigation area. Nine auditors (18.0 FTE staff years, $349,805) are recommended to perform the increased level of required audits. Eleven hearing examiners (22.0 FTE staff years, $417,118) are recommended to meet the increase in workload created by the state's conversion to the Federal Supplemental Security Income program for aged, blind, and disabled public assistance recipients.

Six positions (12.0 FTE, $205,980) are recommended for an additional operations review team.

Category Employment	*1972-73 Actual*	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Proposed*	*1976-77 Proposed*
FTE Staff Years	85.0	98.7	111.0	168.4	175.6
Average FTE Staff Year Costs	11,904	12,349	13,102	12,657	13,143
Expenditure Detail					
Salaries and Wages	1,011,910	1,218,847	1,454,388	2,131,471	2,307,969
Personal Service Contracts	3,100	20,348	45,885	....	....
Goods and Services	86,261	133,891	144,933	318,099	345,059
Travel	95,950	97,438	154,402	188,840	193,413
Equipment	31,538	16,284	2,579	29,701	8,132
Employee Benefits	115,358	182,980	239,490	371,002	394,801
Interagency Reimbursement	....	(13,861)	....	(19,198)	(19,198)
ANNUAL TOTAL	1,344,117	1,655,927	2,041,677	3,019,915	3,230,176
FISCAL YEAR 1971-72	1,007,755				
BIENNIUM TOTAL	2,351,872	3,697,604		6,250,091	
Source of Funds					
General Fund—State	425,681	987,538	1,225,006	1,857,248	1,986,559
General Fund—Federal	750,959	668,389	816,671	1,162,667	1,243,617
Contingent Receipts Fund—Federal—Unanticipated	167,477	....	....	....	....
ANNUAL TOTAL	1,344,117	1,655,927	2,041,677	3,019,915	3,230,176

Exhibit E cont.

FISCAL SERVICES

Category Description

The category has two components, budgeting and accounting. The budgeting activity includes planning, development, interpretation, and coordination of departmental budgets. The accounting element encompasses the preparation and control of payroll and payment documents and the analyses and interpretation of accounting and fiscal data reflecting departmental activities.

Budget Justification

An increase of $1,187,239 and 50.9 FTE staff years is recommended for this category, of which $472,297 and 8.9 FTE staff years are needed to maintain the current staff and level of service. Seven positions (14.0 FTE staff years, $285,292) are recommended to provide a program analysis capability within the budget function. Fourteen positions (28.0 FTE staff years, $429,650) are recommended for the accounting function, primarily to meet current and projected workload.

Category Employment

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Proposed*	*1976-77 Proposed*
FTE Staff Years	222.7	217.0	225.9	246.9	246.9
Average FTE Staff Year Costs	8,461	8,933	9,692	9,793	10.152

Expenditure Detail

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Proposed*	*1976-77 Proposed*
Salaries and Wages	1,884,458	1,938,635	2,189,505	2,418,122	2,506,687
Personal Service Contracts	10,065	94,783	110,966	118,500	169,000
Goods and Services	382,411	523,739	504,533	556,141	503,521
Travel	962	11,426	9,032	19,609	14,481
Equipment	44,681	5,377	52,468	68,707	7,150
Employee Benefits	217,834	318,222	392,562	470,869	485,700
Interagency Reimbursement	(96)	....	....	....	....
ANNUAL TOTAL	2,540,315	2,892,182	3,259,066	3,651.948	3,686,539
FISCAL YEAR 1971-72	2,394,818				
BIENNIUM TOTAL	4,935,133	6,151,248		7,338,487	

Source of Funds

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Proposed*	*1976-77 Proposed*
General Fund—State	1,001,168	1,078,521	1,955,440	2,245.949	2,267,222
General Fund--Federal	1,208,706	1,813,661	1,303.626	1,405,999	1,419,317
Contingent Receipts Fund—Federal—Unanticipated	330,441	....	....	....	....
ANNUAL TOTAL	2,540,315	2,892,182	3,259,066	3,651,948	3,686,539

Exhibit E cont.

SPECIAL PROJECTS

Category Description

Special Projects enhance the operation of the entire program because they include activities that are apart from the everyday activities of the Department. Special projects are surveys, studies and demonstration projects that are funded individually for a specific period of time and must be renewed at the end of each period.

Budget Justification

An increase of $613,116 and a reduction of 8.2 FTE staff years are recommended for this category. Projects to be initiated or continued in the 1975-77 Biennium include the Seattle Income Maintenance Experiment, the Washington Economic Security Test, the colleges and universities training program, and monitoring of contracts paid for from federal social service revenues.

Category Employment

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Proposed*	*1976-77 Proposed*
FTE Staff Years	198.2	45.4	27.8	32.5	32.5
Average FTE Staff Year Costs	3,466	9,842	13,737	12,832	13,369

Expenditure Detail

Salaries and Wages	687,079	446,863	381,899	417,051	434,497
Personal Service Contracts	216,547	307,334	2,039,690	1,511,371	1,507,217
Goods and Services	1,612,885	67,048	(21,264)	111,973	118,057
Travel	17,088	17,675	55,971	49,767	49,767
Equipment	324,049	69,523	31,215	8,068	....
Employee Benefits	82,463	74,860	47,014	67,382	69,677
Interagency Reimbursement	....	(18,000)	....	(113,624)	(117,659)
ANNUAL TOTAL	2,940,111	965,903	2,534,525	2,051,988	2,061,556
FISCAL YEAR 1971-72	329,822				
BIENNIUM TOTAL	3,269,933	3,500,428		4,113,544	

Source of Funds

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Proposed*	*1976-77 Proposed*
General Fund—State	509,059	(5,163)	13,104	....	....
General Fund—Federal	....	966,681	2,518,820	2,051,988	2,061,556
General Fund—Local	....	4,385	2,601	....	....
Contingent Receipts Fund—Federal—Unanticipated	2,376,647	....	....	....	....
Contingent Receipts Fund—State—Unanticipated	54,405	....	....	....	....
ANNUAL TOTAL	2,940,111	965,903	2,534,525	2,051,988	2,061,556

Exhibit E cont.

PROGRAM SUPPORT

Category Description

The category provides administrative support services not included in the other categories of the Administration and Supporting Services program. It includes such activities as program analysis and technical standards, quality control, management analysis, building and office services, contract administration, administrative procedures and records management, inventory control, procurement, and mailroom and stockroom activities.

Budget Justification

An increase of $3,716,118 and 257.4 FTE staff years is recommended for this category, of which $2,570,283 and 199.4 FTE staff years are required to maintain the current staff and level of service. Most of this increase results from the transfer of the Office of Program Analysis and Technical Standards to this category.

Nineteen positions (38.0 FTE staff years, $631,154) are recommended to expand the quality control program to the Supplemental Security Income and Title XIX (Medicaid) areas and to expand the standard-setting and program analysis functions to include all Department programs. Also recommended are ten positions (20.0 FTE staff years, $343,505) to augment Department productivity efforts. Finally, $171,176 is recommended to cover the administrative costs for the monthly reporting of medical benefits and the twice-monthly grant payments in the public assistance area.

Category Employment

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Proposed*	*1976-77 Proposed*
FTE Staff Years	81.9	71.6	100.0	215.0	215.0
Average FTE Staff Year Costs	9,198	10,360	11,568	11,515	12,034

Expenditure Detail

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Proposed*	*1976-77 Proposed*
Salaries and Wages	753,359	741,841	1,156,839	2,475,871	2,587,431
Personal Service Contracts	20	2,381	....	....	....
Goods and Services	1,224,409	1,452,450	1,252,337	1,262,440	1,135,379
Travel	25,269	30,668	69,748	150,500	150,500
Equipment	28,683	15,081	9,159	28,702	49,866
Employee Benefits	91,057	116,123	194,717	450,884	465,889
Interagency Reimbursement	(707)	....	....	....	....
ANNUAL TOTAL	2,122,090	2,358,544	2,682,800	4,368,397	4,389,065
FISCAL YEAR 1971-72	901,374				
BIENNIUM TOTAL	3,023,464	5,041,344		8,757,462	

Source of Funds

	1972-73 Actual	*1973-74 Actual*	*1974-75 Estimated*	*1975-76 Proposed*	*1976-77 Proposed*
General Fund—State	734,839	1,516,001	1,386,341	2,686,561	2,699,271
General Fund—Federal	1,122,105	833,428	1,296,555	1,681,836	1,689,794
General Fund—Local	....	9,115	(96)	....	....
Contingent Receipts Fund—Federal—Unanticipated	265,146	....	....	....	....
ANNUAL TOTAL	2,122,090	2,358,544	2,682,800	4,368,397	4,389,065

EXHIBIT F

CHAPTER 388-96

NURSING HOME ACCOUNTING AND REIMBURSEMENT SYSTEM

NEW WAC 388-96-300 REQUIRED REPORTS. The provider, to receive payments under the cost-related reimbursement system for providing care to medical recipients, will submit an annual report and semiannual report based on the facility's fiscal year.

NEW WAC 388-96-303 UNIFORM REPORTING FORMS. (1) The report shall conform to the uniform reporting system defined in the worksheet forms supplied by the department.

(2) The annual and semiannual reports shall consist of:

(a) Provider information and statistical data.

(b) Financial statements consisting of a balance sheet, statement of changes in equities or fund balances, and statement of operations.

(c) Detailed cost statements, related worksheets, and supporting calculations.

(d) Final daily payment rate determination statement.

(e) Annual and semiannual patient statistical data.

(f) Patient care personnel - RNs, LPNs, aides - and other provider personnel.

(g) All other annual and semiannual data relevant to the justification and support of the cost-related reimbursement system.

(3) The uniform reporting forms and preparation instructions are contained in this provider manual.

(4) The filing of these reports will enable the department to:

(a) Make comparisons of operating expenses among, and between, classification of providers.

(b) Project in a uniform manner the financial characteristics of the industry on the basis of factual data.

(c) Share data to enhance the cost effectiveness of operations.

(d) Review licensing, staffing requirements, monitoring of nursing service reimbursement rates, and availability of beds in geographic areas.

NEW WAC 388-96-306 SHORT-PERIOD REPORT PROCEDURE. A new provider or one changing their fiscal year must contact the department and will file reports as required by the department.

NEW WAC 388-96-309 INCORRECT OR FALSE REPORT. (1) A provider willfully or intentionally filing a report with incorrect or false information will be subject to penalties to be imposed by the department.

(2) The penalties may include:

(a) Immediate stop payment.

(b) Immediate adjustment in the prospective rate along with retroactive recovery of any overpayments.

(c) Cancellation or suspension of the agreement.

(d) Referral for prosecution under applicable Washington statutes.

NEW WAC 388-96-312 AMENDED ANNUAL OR SEMIANNUAL REPORT. (1) A provider must file an amendment to a previously filed report when errors or omissions are discovered which would result in an adjustment.

(2) The payment and period covered by this provision are governed by WAC 388-96-406.

NEW WAC 388-96-315 FLAT RATE OPTION FOR PROVIDERS (FLAT RATE SYSTEM). Refer to Cost Reimbursement Manual, Chapter 2, paragraph 204.00, Flat Rate Payment System Option.

NEW WAC 388-96-318 REPORTING REQUIREMENTS. (1) All providers of services to medical recipients will submit two cost-related reimbursement system reports to the department as follows:

(a) Semiannual reports: 60 days after the end of the sixth month of the provider's fiscal year.

(b) Annual reports: Covering the provider's complete fiscal year 90 days after the end of the provider's fiscal year (tax year).

(2) These reports require uniform financial and statistical data that must be available within the record system of the provider.

NEW WAC 388-96-321 EXTENSIONS. The department may, upon written request prior to the expiration of the appropriate time period, grant a 15 day extension of time for the filing of the annual and semiannual report.

NEW WAC 388-96-324 DELINQUENT SEMIANNUAL OR ANNUAL REPORTS. If a required report is not received by the department within the allowable time period, including any approved extensions, all payments to the provider, at the discretion of the department, will be terminated until the report is received.

NEW WAC 388-96-327 DETERMINATION OF PROSPECTIVE DAILY PAYMENT RATE. All annual reports will be processed in order of their receipt. The department will be allowed 30 days for the determination of a new prospective daily payment rate after submission of the annual report for the subsequent time period. (WAC 388-96-451.)

NEW WAC 388-96-330 RATE ADJUSTMENTS AND PAYMENTS. The department will make a rate adjustment and payments for the

period between issuance of the facility's first prospective rate and July 1, 1975. All subsequent rate adjustments will be effective on the date issued and will run until issuance of a new prospective rate. (WAC 388-96-451.)

NEW WAC 388-96-333 ANNUAL REPORT SETTLEMENT. (1) The annual settlement with the provider for the previous report period will be made within 60 days after the completion of the field audit. (WAC 388-96-473.)

(2) The department will request a refund when the prospective daily payment rate was greater than the provider's audited allowable expenses. The refund shall be paid by the provider within 60 days after the receipt of the request for refund in accordance with the repayment schedule determined by the department. If the refund is not paid within these 60 days, the department will withhold payments from current billings until the requested refund is satisfied.

NEW WAC 388-96-336 CONTESTED ANNUAL SETTLEMENT. In cases of contested annual settlements appeals must be made as provided in WAC 388-96-700.

NEW WAC 388-96-339 FINAL SETTLEMENT DATE. An annual settlement will become final 60 days from the completion of the field audit or three years from the date of filing the annual report.

NEW WAC 388-96-342 UNIFORM SYSTEM OF ACCOUNTING AND REPORTING. The completion of the financial report forms shall be in accordance with generally accepted accounting principles unless the principles, rules, regulations, and instructions authorize specific variations. The providers will maintain their records so that they can be audited in accordance with the appropriate uniform chart of accounts and reimbursement principles established by the department.

NEW WAC 388-96-345 UNIFORM STATISTICAL REPORTING. All providers must comply with the statistical reporting requirements as outlined in the annual and semiannual reports. The providers will maintain their records so that they can be audited in accordance with the statistical report requirements.

NEW WAC 388-96-348 METHOD OF ACCOUNTING. (1) The provider will use the accrual basis of accounting in accordance with generally accepted accounting principles for financial reporting to the department.

(2) The department may, in unique situations, permit the use of a cash or modified cash basis of accounting. No final settlement will be made to providers in this category until completion of a field audit.

NEW WAC 388-96-351 PROVIDER REPORTS. (1) The financial and statistical reports from the provider have been classified as "working papers" of the department of social and health services and will not be available for public disclosure.

(2) The department will utilize the statistical and financial data of each provider to compile an industry analysis for an evaluation of the reimbursement cost system and the administration of this medical recipient program in conformity with state and federal laws, rules, and regulations.

(3) The data compiled by the department will be made available to the industry, and a summary of the data will be available for public disclosure.

NEW WAC 388-96-354 FINAL SETTLEMENT REPORT. The final settlement with the provider, including the provider's reply, will become a public document and subject to full disclosure under RCW 42.17 (Initiative 276). An illustration of this final settlement form is contained within 388-96-387.

NEW WAC 388-96-357 PROVIDER RECORDS. (1) The provider shall maintain all financial and statistical data to support the required reports for a period of three years subsequent to completing and filing the reports for review and examination by the department or for a three-year period of time consistent with the date the settlement is final.

(2) The records of the provider will be available for review by authorized department personnel during normal business hours. These records will be available at a location specified by the provider in the state of Washington. In the event business is discontinued, no final settlement will be made until accessibility and preservation of the final records are assured.

NEW WAC 388-96-360 AUDITS BY THE DEPARTMENT. (1) The provider's report will be subject to a desk review. The report will also be audited in the field to determine that the data is in agreement with the supporting records.

(2) The department shall normally notify the provider two weeks in advance of the field audit.

(3) The field audits will include a review of the provider's record keeping and accounting practices. The department shall make written recommendations for improvement in the provider's record system to ensure appropriate reporting under the cost reimbursement system.

(4) The department will furnish to the provider a copy of the working papers which reconciles the field audit, the provider's annual report, and proposed amounts for final settlement.

(5) The financial data of the provider's annual report must be reconciled by the provider with the applicable federal income tax return and year-end financial statement. These reconciliations shall be prepared on-site by the department's field auditors.

NEW WAC 388-96-363 REPORT CERTIFICATION. (1) The provider's annual and semiannual report will be accompanied by a certification to be signed by an owner, a partner, a corporate officer or that individual who normally signs the federal income tax return of the facility, and the licensed administrator.

(2) If the provider's report has been prepared by someone other than an employee, a separate statement signed by the individual preparing the annual and semiannual report shall be included with the certification indicating their status with the provider.

NEW WAC 388-96-366 THE PROVIDER SHALL ESTABLISH AND MAINTAIN. (1) As a service to the recipient, a bookkeeping system, incorporated in the business records, adequate for audit, for all recipient moneys entrusted to and received by the facility for the recipient.

(2) The system will apply to the recipient who is:

(a) Incapable of handling his own money and whose guardian, relative, department economic and social service office administrator, or physician makes written request of the facility to accept this responsibility; if the social security form SSA-780, "certificate of applicant for benefits on behalf of another," is utilized as documentation, it must be signed by one of the persons designated in this subparagraph.

(b) Capable of handling his own money, but requests the facility in writing to accept this responsibility.

(3) It shall be the responsibility of the provider to maintain such written authorization in the recipient's file.

NEW WAC 388-96-369 THE PROVIDER SHALL MAINTAIN A SUBSIDIARY LEDGER WITH AN ACCOUNT FOR EACH RECIPIENT FOR WHOM THE PROVIDER HOLDS MONEY IN TRUST. (1) Each account and related supporting information shall:

(a) Be kept current.

(b) Be balanced each month.

(c) Show in detail, with supporting verification, all moneys received on behalf of the individual patient and the disposition of all moneys so received.

(2) Each account shall be available for audit and inspection by a department representative and be maintained for a minimum of three years. The provider further agrees to notify the economic and social service office of the department when:

(a) The account of any "grandfathered" recipient whose award letter indicates a limit of $200.00 cash reaches the sum of $175.00. The $200.00 is a limitation as long as the recipient retains "grandfathered" status.

(b) The account of any recipient certified on or after January 1, 1974, whose award letter indicates a limit of $1,500.00 reaches the sum of $1,450.00.

(c) For both groups, the accumulation toward the limit, after admission to the facility, is permitted only from savings from the clothing and personal incidentals allowance and other income which the department specifically designates as exempt income from time to time.

(d) No recipient account may be overdrawn (show a debit balance). If a recipient wants to spend an amount greater than in such recipient's trust account, the home may provide money from its own funds and collect the debt by installments from that portion of the recipient's allowance remaining at the end of each month. No interest may be charged to patients for such loans.

NEW WAC 388-96-372 THE PROVIDER MAY MAINTAIN A PETTY CASH FUND ORIGINATING FROM TRUST MONEYS OF AN AMOUNT REASONABLE AND NECESSARY FOR THE SIZE OF THE FACILITY AND THE NEEDS OF THE PATIENTS, NOT TO EXCEED $500.00. (1) This petty cash fund shall be an imprest fund. All moneys over and above the trust fund petty cash amount shall be deposited intact in a trust fund checking account, separate and apart from any other bank account(s) of the facility or other facilities.

(2) Cash deposits of recipient allowances must be made intact to the trust account within one week from the time that payment is received from the department, social security administration, or other payor.

(3) Any related bankbooks, bank statements, checkbook, check register, and all voided and cancelled checks, shall be made available for audit and inspection by a department representative, and shall be maintained by the home for not less than three years.

(4) No service charges for such checking account shall be paid by recipient trust moneys.

(5) The trust account per bank shall be reconciled monthly to the trust account per patient ledgers.

NEW WAC 388-96-375 TRUST MONEYS CONTROL/DISBURSEMENT. Trust moneys shall be held in trust and are not to be turned over to anyone other than the recipient or his guardian without the written consent of the recipient, his designated agent as appointed by Power-of-Attorney, or appropriate department of social and health services escrow personnel as designated by the ESSO Administrator.

NEW WAC 388-96-378 TRUST MONEYS AVAILABILITY. Moneys so held in trust for any recipient shall be available for his or her personal and incidental needs when requested by the recipient or one of the individuals designated in WAC 388-96-375.

NEW WAC 388-96-381 PROCEDURE FOR REFUNDING TRUST MONEY (1) When a recipient is discharged and/or transferred, the balance of the recipient's trust account will be returned to the individuals within one week designated in WAC 388-96-375 and a receipt obtained. In cases it may be advisable to mail the refund to the recipient's new residence.

NEW WAC 388-96-384 WHEN A PATIENT EXPIRES. (1) When a patient expires, the ESSO caseworker should be contacted to assist the facility in the proper release of any trust fund balances remaining. The cancelled check to the appropriate party will act as a receipt of the funds.

NEW WAC 388-96-387 ILLUSTRATION OF FINAL SETTLEMENT FORM

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
OFFICE OF OPERATIONS REVIEW - AUDIT SECTION - MS 332
OLYMPIA, WASHINGTON 98504
(206) 753-2720

PROVIDER FINAL SETTLEMENT STATEMENT
For Period __________

Name: Vendor No:

Address:

Reimbursable Allowable Costs and Discretionary Allowance $

Less Payments Received from DSHS __________

Balance Due Provider/(DSHS)

Add or Subtract Other Adjustments:

Interim Settlement Payments By:

____

______________________________ $

Other (specify) ______________

______________________________ __________ __________

Balance Due Provider/(DSHS) $__________

Provider Comments Attached:

NEW WAC 388-96-400 COST-RELATED REIMBURSEMENT SYSTEM.

(1) In the cost-related reimbursement system, the patient care cost centers maximum allowable per diem costs for each provider, by classification of care, will be established by the department.

(2) The provider will also receive within the prospective rate a discretionary allowance determined by the department.

(3) The cost-related reimbursement system will determine individual provider rates to recognize the differences in costs for quality patient care and ensure that only reasonable or actual costs, whichever are lower, are reimbursed by public funds.

(4) After determining the allowable cost of patient care and identifying available resources, the department of social and health services will establish standards of care for patients and facility standards for which the department is prepared to pay.

NEW WAC 388-96-403 LIDDED CONTROL AREAS AND ASSOCIATED PATIENT CARE COST CENTERS. (1) The lidded control areas and associated patient care cost centers shall consist of the following:

(a) Prospective daily payment rate	(i) Lidded Control Area #1	(A) Nursing Services
		(B) Restorative care, consultants and activities
		(C) Dietary
		(D) Facility and patient services
		(E) Administration and general
	(ii) Lidded Control Area #2	(A) Operation of Plant
		(B) Payroll taxes
	(iii) Lidded Control Area #3	(A) Property and related
	(iv) Fixed	(A) Discretionary Allowance

(2) The prospective daily payment rate, which is the maximum amount that a facility may receive, consists of eight cost centers plus a discretionary allowance. There is an overall maximum lid plus three individual lids which represent the maximum payment that a facility might receive. The first lidded control area consists of five patient care cost centers: nursing services, restorative care, dietary, facility and patient services, and administration and general. The second lidded control area consists of two cost centers: operation of plant and payroll taxes. The third lidded control area consists of the property and related cost center.

(3) Each cost center will have its own budgeted rate. Within lidded control area #1, a facility may shift unspent allowances in dietary, facilities and patient services, and administration and general against cost increases within the five cost centers up to and including 20 percent of the combined rate for the three cost centers of dietary, facilities and patient services, and administration and general. Unlimited shifting is permitted between the nursing services and restorative cost centers. All of the above is only possible as long as the lidded rate is not exceeded.

(4) Unlimited shifting is permitted in lidded control area #2 to the extent that the lidded rate is not exceeded.

(5) Lidded area #3 represents the maximum that the state is willing to pay for the cost of the physical facility for the duration of the prospective rate.

(6) Shifting beyond that described above must be approved in writing by the department.

(7) The items included within these patient care cost centers are described in the detail cost statements and chart of accounts.

NEW WAC 388-96-406 PAYMENT OF THE ACTUAL ALLOWABLE COSTS BY PATIENT CARE COST CENTERS. (1) The final daily payment rate by classification of care shall be the lower of allowable actual costs, or prospective rate, or as adjusted for each lidded control area. Adjustments at the time of final settlement will not be allowed if such adjustments exceed the particular allowance for the lidded control area or the prospective rate established for the facility.

Example

Patient Care Cost Centers and Lidded Control Areas		Actual Audited Cost Per Diem	Allowable Shift	Allowable Adjusted Prospective Per Diem
$ 5.35	Nurs. Serv.	$ 5.70	.35	$ 5.70
.40	Rest. Care	.30	(.10)	.30
2.60	Dietary	2.80	.20	2.80
1.50	Fac. & Pat. Serv.	1.20	(.30)	1.20
2.00	Adm. & Gen.	1.80	(.15)	1.80
$11.85		$11.80		$11.80

In this sample, within lidded control area #1 total actual costs are five cents per patient day less than the prospective rate. Shifting of unspent allowances and cost increases would be allowed up to and including 20 percent of dietary, facility and patient services, and administration and general, or $1.22 ($2.60 + $1.50 + $2.00 x 20%). The $1.22 shifting allowance allows this facility to shift a potential of $.61 of unspent allowances in dietary, facilities and patient services, and administration and general against $.61 of cost increases in any of the five cost centers. Shifts made between nursing and restorative are unlimited and are not counted as part of the $1.22 shifting allowance for this facility.

NEW WAC 388-96-409 DISCRETIONARY ALLOWANCE. Each provider will receive a discretionary allowance within the provider's prospective rate. This discretionary allowance will be a fixed amount identical for all providers.

NEW WAC 388-96-412 EXPENSE ALLOCATION PROCEDURES. The provider's expenses will be classified in accordance with the uniform reporting forms (WAC 388-96-020). The classification of expenses by cost centers shall be in accordance with the cost-related reimbursement system. (WAC 388-96-400 through 388-96-409.)

NEW WAC 388-96-415 EXPENSE IDENTIFICATION. The provider's expenses by cost center shall be by direct identification for the routine expense transactions recorded in the books and records of the provider. Identifiable direct salaries, materials and services applicable to two or more cost centers shall be distributed to the applicable cost centers when recording the transactions in the books and records. The rationale for such distribution will be part of the documentation.

NEW WAC 388-96-418 EXPENSE RECOVERIES AND ADJUSTMENTS. The provider's expenses recorded in the records will be decreased/increased for the expense recoveries and adjustments in accordance with the principles of recoverable cost as defined in WAC 388-96-600 and 388-96-664.

NEW WAC 388-96-421 ALLOCATION OF EXPENSES. (1) The provider shall allocate expenses by defined cost centers (WAC 388-96-400 through 388-96-409) by classifications of care in the annual and semiannual report. Cost center expenses shall be allocated to classifications of care based on patient days.

(2) "This paragraph shall not be applicable to a multi-facility." (WAC 388-96-424 through 388-96-442.) This cost allocation method shall not be applicable to the distinct part facility that records direct expenses by classifications of care.

(3) The provider must request and receive approval in writing prior to any change in the allocation method for it to be allowed in the annual report.

NEW WAC 388-96-424 MULTI-FACILITY PROVIDER. (1) A multi-facility provider is defined as:

(a) A hospital + skilled nursing home facility and intermediate care facility, or

(b) A retirement home + skilled nursing facility and intermediate care facility.

(2) The multi-facility may include:

(a) A separate and distinct SNF and/or ICF certification.

(b) A combined SNF and/or ICF within the same building(s) of the hospital or retirement home.

NEW WAC 388-96-427 UNIFORM SYSTEM OF ACCOUNTING. (1) The multi-facility shall maintain their records in conformity with the generally accepted accounting principles of the prime service of the provider.

(2) The hospital shall maintain their records in accordance with rules and regulations of the regulatory agencies (hospital commission, medicare and medicaid intermediaries, etc.) and generally accepted accounting principles.

NEW WAC 388-96-430 SEPARATE AND DISTINCT SNF AND/OR ICF. (1) A multi-facility provider with a separate and distinct SNF and/or ICF maintaining separate accounting records for revenues and expenses will report under WAC 388-96-400 through 388-96-409 of the prospective cost reimbursement system.

(2) This multi-facility provider may allocate selected expenses from the central organization to the SNF or ICF. Examples of these selected expenses to be allocated could include:

(a) Dietitian salaries.
(b) Maintenance salaries.
(c) Administrative expenses.

(3) However, 85 percent or more of the total expenses of the SNF or ICF must be accounted for as direct costs identified with the separate and distinct unit. If this multi-facility provider's direct costs are less than 85 percent of total expenses, the provider must adopt the cost allocation method for combined multi-facility providers. (WAC 388-96-424 through 388-96-442.)

NEW WAC 388-96-433 COMBINED MULTI-FACILITY. (1) A combined multi-facility provider (hospital - SNF and ICF or retirement home - SNF and ICF) will adopt the special principles of cost allocations and financial reporting.

(2) This provider will determine the expenses of operating the SNF or ICF using the departmental ration of costs to charges method of cost finding as defined by the medicaid rules and regulations.

(3) The provider will prepare the following schedules to define the direct and allocated expenses of the SNF or ICF.

(a) Schedule A - reclassification of trial balances of expenses.

(b) Schedules A-1 through A-5 - expense analysis schedules.

(c) Worksheet B and B-1 - cost apportionment - general services.

(4) The provider shall be allowed, through the A-5 schedule and worksheet B and B-1, the special principles of reimbursement for depreciation, interest, compensation of owners, and costs of related organizations. (WAC 388-96-600.)

The provider will also be allowed special allocation methods for the apportionment of administration and general expenses.

NEW WAC 388-96-436 PROSPECTIVE COST REIMBURSEMENT FOR COMBINED MULTI-FACILITY. (1) The combined multi-facility provider will have his or her prospective per diem costs determined on a total SNF or ICF basis.

(2) This provider shall develop his or her total SNF or ICF per diem costs by the following cost centers:

(a) Direct expenses (schedule A).
(i) Nursing services.
(a) Salaries and wages - RN.
(b) Salaries and wages - LPN.
(c) Salaries and wages - aides and orderlies.
(d) Salaries and wages - ward clerks.
(ii) Nursing supplies.
(b) Allocated expenses (worksheet B).
(i) Depreciation.
(a) Land improvements.
(b) Building and fixed equipment.
(c) Interest on long-term debt.
(d) Facility insurance (fire, extended coverage, etc.).
(e) Movable and minor equipment.

(The depreciation options of WAC 388-96-610 may be adopted by the provider.)

(c) Administration and general (selected weighted cost allocations may be adopted by the provider.)

(d) Employee health and welfare.
(e) Operation of plant.
(f) Maintenance of plant including direct allocation of special maintenance required under new regulations by regulatory agencies.
(g) Laundry and linen.
(h) Housekeeping.
(i) Dietary (raw food and other).
(j) Cafeteria.
(k) Maintenance of personnel.
(l) Nursing service administration.
(m) Medical supplies and expenses.
(n) Pharmacy.
(o) Medical records.
(p) Social services.
(q) Therapy - physical, occupation, etc.

NEW WAC 388-96-439 PAYMENT OF THE LOWER OF ACTUAL COSTS OR PROSPECTIVE PER DIEM RATES. The maximum prospective per diem rate by classification of care for combined multi-facility providers shall be established by the department. The hospital-SNF provider will be reimbursed the lower of total actual costs or the maximum prospective per diem rate by classification of care. Multi-facility providers may use the adjustment provisions in WAC 388-96-406.

NEW WAC 388-96-442 MULTI-FACILITY FLAT RATE OPTION FOR PROVIDERS (FLAT RATE SYSTEM). (1) Refer to Cost Reimbursement Manual, Chapter 2, paragraph 204.00, flat rate option.

(2) All multi-facility providers under common ownership or management must qualify for this option to elect this flat rate payment system. Other provisions of Cost Reimbursement Manual, Chapter 2, paragraph 204.00, are applicable to multi-facility providers.

NEW WAC 388-96-445 MEDICAL RECIPIENT RATES. The cost-related reimbursement system provides for the determination of maximum prospective daily payment rates for all medical recipient patients. The medical recipient rates are determined by the cost-related reimbursement system which allocates total patient expenses to the medical recipient patients in accordance with WAC 388-96-400 through 388-96-442.

NEW WAC 388-96-448 MEDICAL RECIPIENT RATES BY LEVEL OF CARE. (1) The prospective daily payment rates for each provider will be determined by level of care:

(a) SNF (skilled nursing care).

(b) ICF (intermediate nursing care).

(2) The nursing service and other service costs are applicable to all patients of similar classifications of care. Therefore, the cost-related reimbursement system does not require a segregation of nursing service and other service costs between the private and medical recipient patients. In no case will the final per diem settlement rate for medical recipient patients exceed the annualized private patient or medicare rate charged by the facility for like classification of care.

NEW WAC 388-96-451 PROSPECTIVE DAILY PAYMENT RATE. (1) The prospective daily payment rate is set for a period of time by classifications of care using the audited yearly cost reports and the previous semiannual cost reports: anticipated cost changes reported by the provider, plus a calculated allowance for projected cost increased in the subsequent time frame. The new prospective daily payment rate shall be effective starting the month in which it is issued.

(2) Subsequent to September 15, 1975, the department may establish new standards of care and/or recognize legally imposed expenses which increase the prospective payment rates. The provider shall receive the increased prospective payment rate, if applicable, without the preparation of a formal request as provided by the paragraphs of this section. This revised prospective payment rate shall only be paid for medical recipient care subsequent to the effective date of the change in rate.

NEW WAC 388-96-454 PROSPECTIVE RATE-- INADEQUATE DATA. (1) The prospective rate for providers without adequate financial and statistical data will be determined by the secretary on the basis of the following factors:

(a) Usual and customary rates for providers with comparable classifications of care in similar geographic and socioeconomic areas.

(b) Anticipated utilization of not less than the average for the geographic area in which the provider is located.

(2) The department will also have the option of continuing to reimburse this provider on a discounted prospective rate. This discounted prospective rate would continue until adequate financial and statistical data can be developed from the provider's records to achieve the reporting requirements specified by the department.

NEW WAC 388-96-457 PROSPECTIVE RATE REVISION. (1) The provider may request a revision of the prospective rate during the year by the submission of projected cost data. (WAC 388-96-458.)

(2) The request for revision in the prospective rate may include the data required under WAC 388-96-458.

NEW WAC 388-96-458 PROSPECTIVE RATE -- PROJECTED (BUDGETED) COST INCREASES. (1) The projected cost increase will be based on the net annualized effect of such increases or decreases not already recognized in the current prospective daily payment rate. (WAC 388-96-451.)

(2) The projected (budgeted) cost increases or decreases used in the determination of a new prospective daily payment rate include the following:

(a) Wage increases - labor contracts.

(b) Wage increases - merit, longevity, and cost of hiring.

(c) Depreciation of major new equipment or facility.

(d) New laws and regulations regarding increased care, operating procedures, or improved facility.

(e) Wage increases - minimum wage laws.

(f) Payroll and property taxes.

(g) Interest.

NEW WAC 388-96-460 PROSPECTIVE RATE -- NEW FACILITY. The prospective daily rate for a new facility or addition to an existing facility will be determined based on:

(a) Comparable prospective daily payment rates in the area for similar facilities and classifications of care, and

(b) Projected cost of operations using the annual reporting form of the cost-related reimbursement system.

NEW WAC 388-96-463 PROSPECTIVE RATE -- CHANGE IN OWNERSHIP - NEW PROVIDER. (1) A preliminary prospective rate for a facility that changes ownership (sole proprietor, partnership, and corporation) without an interruption in the operation can continue for a period not to exceed 90 days as long as the appropriate provisions of the Cost Reimbursement Manual, Chapter 2, are complied with. No payments will be made to a new provider under the old provider's vendor number. The new provider should ensure that prior to the first month's billing that a new vendor number has been assigned by the cost reimbursement section.

(2) The previous owner must file a final annual report for the period of ownership in the current fiscal year as required by the cost reimbursement system. The payment for the final month of service of the old provider will be held until submission of the annual report and determination of a final settlement.

(3) The seller is encouraged to file an annual report as soon as possible after the sale to enable the department to make the final settlement.

NEW

WAC 388-96-466 PROSPECTIVE RATE-- CHANGE IN OWNERSHIP - NON-ARMSLENGTH TRANSACTION. No increase in the facility's prospective daily payment rate will be allowed for non-armslength transactions.

NEW

WAC 388-96-470 PROSPECTIVE RATE-- CHANGE IN OWNERSHIP - ARMSLENGTH TRANSACTION. The department will establish the new prospective rate in the following manner:

(1) The department may determine the prospective rate for the buyer based on:

(i) The seller's prospective rate and the cost of operations, and/or

(ii) The actual and projected (budgeted) cost increases and statistical data for the buyer.

NEW WAC 388-96-473 FINAL DAILY SETTLEMENT RATE. (1) The final daily settlement rate will not exceed the weighted average of the prospective rates paid the provider during the preceding period of time and will be based on the annual report applying the cost-related reimbursement system by classification of care. The final rate shall consist of:

(a) The lower of the actual cost or the prospective per diems for each of the three lidded control areas (WAC 388-96-406), and

(b) The discretionary allowance (WAC 388-96-662).

(2) The final daily payment rate for multi-facility providers shall be the lower of the actual cost or weighted average prospective per diem rate plus the discretionary allowance.

(3) The following is an example of how to calculate the weighted average of the prospective rates paid over a period of time.

(a)

	Prospective Rate (First 6 Months)	Adjustment	Prospective Rate (2nd 6 Months)	Average Prospective Rate for Settlement Prior to Shifting
Nursing Serv.	$ 6.24	$.10	$ 6.34	$ 6.30
Restorative Care	.26	.20	.46	.38
Dietary	2.60		2.60	2.60
Facility & Pat Serv.	1.40		1.40	1.40
Admin. & General	1.80		1.80	1.80
Total	$12.30	$.30	$12.60	$12.48
Operation of Plant	.60		.60	.60
Payroll Taxes	1.10	.02	1.12	1.11
Total	$ 1.70	$.02	$ 1.72	$ 1.71
Property & Related	$ 2.00	$ -	$ 2.00	$ 2.00
Total Per Diem	$16.00	$.32	$16.32	$16.19
Discretionary Allowance	.90		.90	.90
Prospective Rate	$16.90	$.32	$17.22	$17.09
Patient Days	100		150	

(b) Weighted averages:

(i) Nursing Services =

$$\frac{(\$6.24 \times 100 \times 6) + (\$6.34 \times 150 \times 6)}{(100 \times 6) + (150 \times 6)} = \$6.30$$

(ii) Restorative Care =

$$\frac{(\$.26 \times 100 \times 6) + (\$.46 \times 150 \times 6)}{(100 \times 6) + (150 \times 6)} = \$\ .38$$

(iii) Payroll Taxes =

$$\frac{(\$1.10 \times 100 \times 6) + (\$1.12 \times 150 \times 6)}{(100 \times 6) + (150 \times 6)} = \$1.11$$

NEW WAC 388-96-476 NOTIFICATION OF PROSPECTIVE AND FINAL RATES. The department will notify the provider, in writing, of the prospective and final rates determined under these principles along with the effective dates.

NEW WAC 388-96-479 ADJUSTMENTS, ERRORS, OR OMISSIONS. (1) All provider rates determined in accordance with the cost-related reimbursement system may be subject to adjustment as a result of errors or omissions by the state or the provider.

(2) These adjustments are limited to the three complete fiscal years preceding the date of filing the annual report. If the adjustment results in a payment due from the provider, the provider will have up to 60 days after the date of receiving the written notification of the adjustment to make the payment. If the adjustment results in a payment due to the provider, the department shall make the payment within 30 days after the date of notification to the provider.

NEW WAC 388-96-500 PROVIDER BILLING INSTRUCTIONS -- NURSING HOME STATEMENT. (1) The provider shall prepare the nursing home statement in accordance with instructions issued by the medical audit section, department of social and health services. The monthly billing form must be mailed to the department by the 25th of each month.

(2) Information which will be included but not necessarily limited to:

(a) Name and address of facility.

(b) License number.

(c) Facility license classification.

(d) Patient's first and middle initial.

(e) Patient's birthdate and last name.

(f) Patient's classification, period of service, and number of days being billed for. (Day of admit will be counted and day of discharge will not.)

(g) Daily rate which must correspond with patient's class.

(h) Amount paid by patient.

(i) Deduction of amount paid by patient from charge.

(3) Sign each copy and enter date of signature. (Any documents signed by any other than an authorized person will have to be returned for proper completion.)

(4) Mail original copy to: Medical Audit, P. O. Box 9230, Olympia, Washington 98504.

(5) Keep carbon copy for the provider's records.

NEW WAC 388-96-510 BILLING PERIOD. (1) The provider's billing period will be from the first of each month through the end of the month. Please do not enter any days on a document that do not coincide with this billing period.

(2) The provider shall submit a separate nursing home statement for all patient corrections to the regular monthly billing.

(3) In order for the department to correct any improper deletions from the billings, the provider must send the medical ID coupon for each patient being billed for on each statement.

(4) The provider should use extreme care in entering all data on the billing forms so they will be processed and paid promptly for care of the medical recipients.

NEW WAC 388-96-520 SUSPENSION OF REIMBURSEMENT FORMULA. Unless a different amount is fixed by the secretary after his singular determination that there are insufficient funds available, rates shall be set in accordance with the reimbursement formula in WAC 388-96-300 through WAC 388-96-600.

NEW WAC 388-96-600 REASONABLE COSTS. Costs to be allowed for rate setting purposes must be:

(1) Within the funding limitations as established by the Washington State Legislature.

(2) Necessary and ordinary costs related to medical recipient care.

(3) Costs that prudent and cost-conscious management would pay for the item or service.

NEW WAC 388-96-602 SUBSTANCE OF RECOVERABLE COST TRANSACTIONS. The cost effect of transactions that has the effect of circumventing the principles of the cost-related reimbursement system will be disallowed under the principle that the substance of the transaction will prevail over the form.

NEW WAC 388-96-604 COSTS DUE TO CHANGES IMPOSED BY REGULATORY AGENCIES. (1) The costs incurred by the provider to comply with changes in laws and regulations subsequent to July 1, 1974, for increased care of medical recipients and/or improved facilities, as required by the department, will be considered in computing the provider's prospective daily payment rates.

(2) New standards imposed by regulatory agencies subsequent to July 1, 1974, shall be included in the appropriate cost centers under the heading "new standards" in the new chart of accounts.

NEW WAC 388-96-606 NON-REIMBURSABLE SERVICES AND EXPENSES.

(1) The provider expenses not directly or indirectly related to care of medical recipient patients will not be an allowable expense under the cost-related reimbursement system.

(2) The direct and indirect expenses not allowed shall include, but not be limited to, the following items:

(a) Vending machine expenses.

(b) Personal items of cosmetics (hygiene), smoking, periodicals and newspapers, clothing, etc., except those used in activity programs (e.g., prizes).

(c) Fund-raising expenses.

(d) Funeral and burial expenses.

(e) Barber and beauty shop, except for staff providing routine hair care.

(f) Contributions to charitable and political parties.

(g) Penalties and fines.

(h) Telephone, television, and radio in resident's private accommodations.

(i) Federal income taxes.

(j) Bad debt or allowances uncollectable from patients, except those documented as resulting from DSHS error.

(k) Private patient prescription drugs.

(l) Special care salaries.

(m) Therapy services on an individual and separate fee basis.

(n) Personal expenses of owners living in the facility (except those allowable as owner compensation).

(i) Dietary.

(ii) Laundry, linen, housekeeping, plant operations, and maintenance.

(iii) Depreciation, interest, real and personal property taxes.

(iv) Personal expenses.

(v) The expense of administrators or key personnel living in the facility will be allowed providing it is a condition of job performance and this additional compensation is reasonable under these principles.

(o) Owner or key-man life insurance (except those allowable as owner compensation).

(p) Non-related professional, technical, and social organization membership fees.

(q) Non-related travel, entertainment, and automobile expenses.

(r) Profit sharing plan expenses.

(i) Approved or non-approved by the internal revenue service.

(s) Training programs for non-employees.

(t) Non-competitive agreements.

(u) Goodwill resulting from purchase of property or stock in excess of determinable values.

(v) Pre-opening expenses not capitalized and amortized over 60 consecutive months or more after opening.

(w) Legal fees resulting from an action taken by a facility against the department in those cases where a decision was rendered in favor of the department or where otherwise the decision of the department stood.

(3) These expenses are further defined in the chart of accounts - non-allowable expenses. The expenses must be deducted from the balance per books as adjustments in the detail cost statement.

NEW WAC 388-96-608 RECOVERY OF EXPENSES. (1) The provider's recovery of expenses or imputed values of services and activities will be reductions in expenses in the determination of allowable costs under the cost-related reimbursement system.

(2) The amount of the recovery of expenses shall be the actual cost of the services and activities. The amount of these actual costs must be imputed and deducted from the balance per books as adjustments in the detailed cost statement.

(3) The recovery of expenses shall include, but not be limited to, the following items:

(a) Special care services (nursing, therapy, etc.) reimbursed under separate billing arrangements with the department or billed separately to private patients.

(b) Drugs and supplies sold for use outside the facility, i.e., drugs and medical supplies sold or used by owners, administrators, and employees.

(c) Telephone services under a separate charge method.

(d) Discounts on purchases.

(e) Living quarters rented or provided for owners.

(f) Cafeteria sales or meals provided for owners, administrators, and employees unless specified as a condition of employment.

(g) Meals provided to patients' guests, special nurses, etc.

(h) Lease or rent of office and other space used by owners, physicians, therapists, concessionaries and others which are not patient care services included in allowable expenses.

(i) Hourly services rendered on a charge basis for the care of private patients or for owners, administrators, and related organizations.

(j) Tuitions and other payments for educational services, room and board, and other services not related to patient care included within the allowable expenses.

(k) Interest income from non-restricted funds.

(4) Examples of the recovery of expenses, as defined in the chart of accounts, that will be adjustments in the balance per books in the detail cost statement, are as follows:

Recovery of expenses	Cost centers
Income from interest, rentals, leases	Property and related
Purchase discounts	Administration and general
Telephone and television	Administration and general
Laundry	Laundry and linen
Cafeteria sales	Dietary
Meals served to patients' guests, special nurses, etc.	Dietary

NEW WAC 388-96-610 PHYSICAL PROPERTY. (1) It is the intention of the department of social and health services to provide for adequate compensation of physical property costs to encourage the growth of equity, to encourage the continued maintenance and improvement of the physical property, and to provide for incentives to ensure a viable industry capable of providing into the future the needed levels of quality nursing home care.

(2) The following paragraphs provide for three basic alternatives, historical cost, construction index, and reproduction cost method, to determine the cost of physical property. To ensure that the facilities under cost reimbursement clearly understand what costs the department is willing to reimburse, the following guidelines are provided.

(3) The maximum cost of physical property that will be reimbursed by the department independent of the ownership arrangement is determined by the following formula:

(a)

$$\text{Maximum reimbursement for physical property} = \frac{\text{Construction index X adjustment factor + dep. (building) + dep. (equipment)}}{\text{Occupancy factor}}$$

(i) Construction index: The table is taken from option 2, WAC 388-96-614(4). The total value of the facility, land, building, and equipment is calculated on a per bed basis using this table. The total value is broken down accordingly; 10 percent for land, 15 percent for equipment, and 75 percent for the building.

(ii) Adjustment factor: The adjustment factor to be used is 5.00 percent.

(iii) Depreciation - building: Depreciation on the building is taken over 30 years at a rate of 3.33 percent per annum.

(iv) Depreciation - equipment: Depreciation on equipment is taken over ten years at a rate of 10.0 percent per annum.

(v) Occupancy factor: The occupancy factor utilized in this formula will be based upon a 100 percent occupancy of the total number of licensed beds in the facility.

(4) This formula determines the maximum cost of physical property that the department will reimburse. The following guidelines determine how this formula will be applied.

(5) No facility will be given a prospective rate for physical property for more than what this formula computes or the facility's initial 1974 annual settlement for physical property costs under the cost reimbursement system, unless one of the three following conditions apply.

(a) A facility may be allowed to approach the ceiling on physical property costs as established by the formula, providing funding is available, at no more than ten percent per each facility's fiscal year.

(b) An adjustment to the value as determined by the construction index will be allowed, with prior approval of the department, for capital expenditures related to regulatory mandated expenditures.

(c) An adjustment to the value as determined by the construction index will be allowed, with prior approval of the department, for capital expenditures approved as part of the comprehensive health planning process.

(6) When appropriate, the adjustments to the cost of physical property will be included in the facility's new prospective rate.

NEW WAC 388-96-612 DEPRECIATION. (1) Depreciation will be allowed on all depreciable type assets that are used to provide covered services for medical recipients. The appropriate allowance for depreciation shall be:

(a) Identifiable and recorded in the provider's accounting records, or

(b) Identifiable by optional worksheets or records. These identifiable records must be auditable and specify the depreciation methods and elections for the depreciable assets.

(2) The assets subject to depreciation are described as follows:

(a) Building - building includes the basic structure or shell and additions thereto. The remainder is identified as building fixed equipment.

(b) Building fixed equipment - building fixed equipment includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating system, air conditioning system, etc. The general characteristics of this equipment are:

(i) Affixed to the building, and not subject to transfer.

(ii) A fairly long life, but shorter than the life of the building to which affixed.

Since the useful lives of such equipment are shorter than the building, the equipment may be separated from the building cost and depreciated over this shorter useful life.

(c) Major movable equipment - the general characteristics of this equipment are:

(i) A relatively fixed location in the building.

(ii) Capable of being moved as distinguished from building equipment.

(iii) A unit cost sufficient to justify ledger control.

(iv) Sufficient size and identity to make control feasible by means of identification tags.

(v) A minimum life of approximately three years.

(d) Minor equipment - the general characteristics of this equipment are:

(i) In general no fixed location and subject to use by various departments of the provider's facility.

(ii) Comparatively small in size and unit cost.

(iii) Subject to inventory control.

(iv) Fairly large quantity in use.

(v) Generally, a useful life of approximately three years or less.

(e) Land (non-depreciable) - land (non-depreciable includes the land owned and used in provider operations. Included in the cost of land are the costs of such items as off-site sewer and water lines, public utility charges necessary to service the land, governmental assessments for street paving and sewers, the cost of permanent roadways and grading of a non-depreciable nature, the cost of curbs and sidewalks whose replacements are not the responsibility of the provider, and other land expenditures of a non-depreciable nature.

(f) Land improvements (depreciable) - depreciable land improvements include paving, tunnels, underpasses, on-site sewer and water lines, parking lots, shrubbery, fences, walls, etc., if the replacement is the responsibility of the provider.

(g) Leasehold improvements - leasehold improvements include betterments and additions made by the lessee to the leased property. Such improvements become the property of the lessor after the expiration of the lease.

(3) Depreciation will be allowed on assets that are used in normal standby and emergency capacity. These assets must be available for immediate use for patient care.

NEW WAC 388-96-614 HISTORICAL COST DEPRECIATION FOR NEW PROVIDERS AND FOR DEPRECIABLE ASSETS PURCHASED SUBSEQUENT TO JULY 1, 1974. All providers must record and depreciate all additions to depreciable assets purchased subsequent to July 1, 1974, on a historical cost basis. All new providers coming under cost reimbursement must depreciate all additions to depreciable assets on historical cost basis.

NEW WAC 388-96-616 ELECTION OF DEPRECIATION METHOD FOR DEPRECIABLE ASSETS PURCHASED PRIOR TO JULY 1, 1974, FOR PROVIDERS CURRENTLY UNDER COST REIMBURSEMENT. (1) Providers who have elected one of three optional depreciation methods within the filing of their first annual report, will remain on that depreciation method.

(2) The depreciation method applicable to the purchase of a facility as an ongoing operation is discussed in WAC 388-96-624.

(3) Option 1 - historical cost depreciation method.

(a) The historical cost depreciation method is to depreciate the cost incurred by the provider in acquiring the asset and to prepare it for use. Generally, the cost includes the items that would be capitalized under generally accepted accounting principles in addition to the purchase price; historical costs would include architectural fees, consulting fees, installation, and other costs.

(b) The historical cost depreciation method shall be applicable to depreciable costs of land improvements, buildings, fixed equipment and major-minor equipment. (Automotive equipment will only be depreciated on the historical cost basis.)

(4) Option 2 - construction index depreciation method.

(a) The construction index depreciation method is an allowable cost per bed for depreciable assets, including land improvements, buildings, fixed equipment and major-minor movable equipment. The construction index is used to specify the depreciation allowed on the age of the facility as follows:

(i)

Date constructed	Allowance per bed
Prior to 1956	$ 6,000
1956 - 1960	7,000
1961 - 1965	8,000
1966 - 1970	9,000
1971 - June 30, 1974	10,000

(b) Depreciable equivalency based on the above table will be allowed at a rate of 3.33 percent per annum. (Automotive equipment will only be depreciated on the historical cost basis.)

(5) Option 3 - reproduction-cost-depreciation method.

(a) The appraisal method (reproduction-cost-depreciation method) of computing depreciation on depreciable assets utilizes an appraisal of the historical cost of the asset made by a recognized expert, such as M.A.I. (member appraisal institute) and will be acceptable in determining the basis for depreciable assets. The department reserves the right to an additional independent appraisal before accepting the provider's net appraised value and remaining lives for the depreciable assets.

(b) The appraisal of the historical cost of assets should produce a value approximating the costs of reproducing substantially identical assets of like type, quality, and quantity at a price level in a bona fide market as of the date of acquisition.

(c) The provider's depreciation under the appraisal method must be computed on a straight-line basis. The building depreciation total life shall not be less than 30 years in determining the remaining depreciable basis. Other lives shall be determined by the appraisal in accordance with industry standards. (Automotive equipment will only be depreciated on the historical cost basis.)

(i) Appraisal expense - appraisal expense, including that expense for appraisal of personal residence and other nonpatient departments, incurred by a provider after entrance into the program, may be included in allowable cost. Such expenses will be considered as allowable administration and general expenses in the period incurred, subject to apportionment to the medical recipient program. Appraisal expense incurred in appraisal of assets not connected with provider operations may not be included in allowable costs.

(ii) Where providers have appraisals made for other business purposes (insurance coverage, tax values, and financing), the expenses incurred for such appraisals may be included in allowable costs as part of administration and general costs. However, appraisal expense incurred to establish values for the sale or anticipated sale of a provider organization are not includable in allowable costs. Where the department determines that a provider has incurred appraisal expense subsequent to electing this depreciation method to establish the appraisal or historical cost of assets which were already adequately reflected in its books, records or tax return, the cost of performing the appraisal is not allowable.

(iii) The appraisal method, source of data, content, and certification required by the department in the election of this depreciation method have been discussed in the glossary of terms.

NEW WAC 388-96-618 GUIDELINE LIVES AND METHODS OF DEPRECIATION. (1) Under the historical cost depreciation method and the historical cost depreciation on additions subsequent to July 1, 1974, the provider must use the internal revenue service guideline lives and methods in computing depreciation for these defined assets.

(2) The building depreciation will not be computed on less than a 30-year useful life from the date of original construction. Building improvements will be depreciated over the remaining useful life of the principle asset but not less than 15 years. The depreciation computations for land improvements, building, and fixed equipment will be on the straight-line method. The provider may elect to use the straight-line or other recognized accelerated depreciation methods (double declining balance, declining balance or sum-of-years digits) for major-minor equipment. Also, if an accelerated depreciation method is elected, the provider may change to the straight-line method without permission of the department.

(3) The use of straight-line or sum-of-the-years digits method of depreciation for equipment requires that the estimated salvage value (in excess of ten percent of historical cost) be subtracted from the historical cost in the depreciation computation.

NEW WAC 388-96-620 DISPOSAL OF DEPRECIABLE ASSETS. (1) Under the historical and the reproduction-cost-depreciation method, depreciable assets may be disposed of through sale, trade-in, scrapping, exchange, theft, wrecking, fire or other casualty. In such cases, depreciation can no longer be taken on the asset. Gain or loss on the disposition of equipment must be computed by the provider.

(2) Where an asset is being used for standby or emergency services, depreciation may continue to be taken on such assets. However, where the asset has been permanently abandoned, no further depreciation can be taken on the asset. For all equipment, the gain or loss on the retirement must be computed.

(3) Under the construction index depreciation method, the provider shall not record the disposal of assets except through the reduction in the number of beds used by the facility. Gains, losses, or depreciation adjustments shall not be applicable if the depreciation basis is determined on the number of beds.

NEW WAC 388-96-622 GAINS OR LOSSES ON DISPOSITION OF MAJOR-MINOR EQUIPMENT. (Gains (recovery) or losses (expense) on the disposition of major-minor equipment are includable in computing allowance costs.)

(1) The gain or loss on the disposition of equipment will be prorated for the period used under the program. The amount of gain or loss on the item of equipment to be included shall be that portion computed on the basis of total depreciation taken compared to that portion of depreciation taken subsequent to July 1, 1974. The gain (recovery) to be included in allowable costs shall be limited to the amount of depreciation taken subsequent to July 1, 1974, for the item of equipment.

(2) The loss (expense) to be included in allowable costs shall not exceed:

(a) The prorated loss, or

(b) The amount of depreciation claimed on the item of equipment subsequent to July 1, 1974.

NEW WAC 388-96-624 HISTORICAL COST TRADE-INS. (1) When an asset is acquired by trading in an asset that was depreciated under this program, the cost of the new asset would be the sum of the undepreciated balance of the old asset and the cash paid or to be paid under purchase arrangements which evidence compliance with a regular payment schedule. Where an old asset was acquired by the provider before entrance into the program, and the sum of the undepreciated balance and the cost paid or to be paid exceeds the list price, the cost of the new asset will be the list price.

(2) For assets having no historical or appraisal values assigned, the cost basis shall be the fair market value at the date of disposal of the old asset plus the sum paid but not to exceed the list price.

NEW WAC 388-96-626 PURCHASE OF FACILITY AS AN ONGOING OPERATIONS. In the event of a bona fide sale of a facility after July 1, 1974, the basis of depreciation under the cost-related reimbursement system to be used by the purchaser will be:

(a) The price paid for the facility, or

(b) If the bona fide price paid and the allocated values are challenged by the department, the fair market value of the facility will be established by an M.A.I. appraisal.

NEW WAC 388-96-628 PARTIAL CHANGE OF OWNERSHIP INTERESTS.

(1) Where a provider shall incur a partial change of ownership through a bona fide sale or redemption, the basis for calculating historical cost depreciation will be the book value increased by the excess, if any, of the sale or redemption price over the former owner's investment, in accordance with the provisions of these depreciation principles. If the bona fide price paid and the allocated values

are challenged by the department, the fair market value of the facility will be established by an M.A.I. appraisal.

(2) For purposes of this paragraph, a partial change in ownership occurs only in the case of an ongoing concern (partnership, joint venture, etc.) with ten or fewer owners, after the change in ownership, and when the ownership change exceeds 20 percent. This change in ownership must be recorded in the provider's records or accompanying schedules.

NEW WAC 388-96-630 DONATED ASSETS. (1) The basis of donated assets, except for donations between providers or related organizations, shall be the fair market value defined as the price that an able buyer would pay a willing seller in an arms-length transaction or appraised value, whichever is lower.

(2) An asset is considered donated when the provider acquired the asset without making any payment for in in the form of cash, property, or services. In the instance of donations between related organizations, net book value to the donor shall be the basis for the donee.

NEW WAC 388-96-632 CAPITALIZATION VS. EXPENSE. The expenditures for equipment with a unit basis of over $150 (except group purchases) and that have a useful life of more than one year shall be capitalized and depreciated in the computation of allowable expenses under the cost reimbursement system.

NEW WAC 388-96-634 CONSTRUCTION IN PROCESS. (1) All costs related to the construction, improvement, betterment, or replacement of a facility (land improvements, building, building fixed equipment, and major-movable equipment), will be capitalized and recorded as construction in process if the project is not substantially completed at the end of the provider's fiscal or calendar year.

(2) The costs of the project, as defined by WAC 388-96-610, shall pertain to patient care. If the project is abandoned or discontinued on a permanent basis (not resumed within a two-year period), the costs may be recovered as a property and related expense over a period of not less than 60 months after the expiration of the two-year waiting period.

NEW WAC 388-96-636 AMORTIZATION EXPENSE OF LEASEHOLD IMPROVEMENTS. The shorter of the useful life of the improvement or the remaining term of the lease, including renewal periods, shall be used in determining the amortization expense on a straight-line basis.

be a deduction from interest expense. These non-restricted funds are defined as operating, building, or board designated funds.

(3) The interest income from restricted funds would not be a deduction from interest expense. These restricted funds are defined as those designated by the donors, governmental units, and endowments for special purposes such as equipment purchases, building improvements, and research. This interest income must be separately funded and not available for use by the provider for operations.

NEW WAC 388-96-646 INTEREST EXPENSE - RELATED ORGANIZATION. The net interest expense (interest expense less interest income) will be allowed on the total amount of debt as modified (WAC 388-96-640 and 388-96-642) from a related organization providing the interest income of the related organization has been prorated to the provider. The interest rate paid to a related organization will not be in excess of what a prudent borrower would have to pay at the time of the loan in an arms-length transaction in the money market.

NEW WAC 388-96-648 CONSTRUCTION INTEREST EXPENSE. The interest expense incurred during and related to construction must be capitalized as a part of the facility. The period of construction shall extend from the date of the construction loan to the date the facility is put into service for patient care. (See WAC 388-96-632 for construction in process.)

NEW WAC 388-96-650 IN-SERVICE EDUCATIONAL ACTIVITIES.

(1) Allowable costs shall include the expenses related to employee education, orientation, and on-the-job training to improve patient care.

(2) All in-service educational expenses, including the salaries and wages, travel, registration, etc., of the employees for participating in these training programs, shall be recorded in the respective cost centers such as nursing services, dietary, etc., or administration and general.

(3) Expenses of training programs for non-employees, except volunteers, will not be an allowable expense of the provider.

NEW WAC 388-96-652 OWNER-ADMINISTRATOR COMPENSATION AND/OR ALLOWANCES. (1) The reasonable compensation and/or allowances paid or imputed for an owner-administrator of record for services actually or required to be performed will be considered an allowable cost to be included within the administration and general cost center.

(2) The maximum allowable total compensation and/or allowances for an owner functioning as a licensed administrator and included in the administration and general cost center will not exceed the amounts in the following table:

TABLE

Owner-Administrator Compensation and Allowance

	Annual	Month
Maximum compensation for 40 beds or less	$12,000	$1,000
Additional allowance for increasing bed size 41 through 60 beds	+ 180	+ 15
Maximum compensation for 60 beds . . .	$15,600	$1,300
Additional allowance for increasing bed size 60 through 80 beds	+ 150	+ 12.50
Maximum compensation for 80 beds . . .	$18,600	$1,550
Additional allowance for increasing bed size 80 through 200 beds	+ 96	+ 8
Maximum compensation for 200 beds . . .	$30,120	$2,510
Additional allowance for increasing bed size 201 and above	+ 12	+ 1
Example:		
Bed Size 70 beds		
Maximum Compensation for 60 beds .	$15,600	$1,300
Additional allowance for 10 beds		
Annual - 10 x 150 =	1,500	
Month - 10 x 12.50 =		125
Total Maximum Compensation for 70 beds	$17,100	$1,425

NEW WAC 388-96-654 RELATIVES OF OWNER COMPENSATION AND/OR ALLOWANCES. (1) The reasonable compensation and/or allowances paid for the relatives of owners shall be equal to that normally required to be paid to non-related employees, including all fringe benefits as defined by WAC 388-96-658.

(2) The provider must maintain adequate time records for the relatives of the services performed to substantiate and justify the compensation and/or allowance as an allowable cost. The amount of compensation of the relatives shall be recorded in the appropriate cost center or included in administration and general expenses.

NEW WAC 388-96-656 OWNER-ADMINISTRATOR OF MULTIPLE FACILITIES (GROUPS). The amount of compensation and/or allowances paid or imputed for the owner providing services to two or more providers (groups) shall be limited to the number of beds in the facility for which the administrator has primary management responsibility.

NEW WAC 388-96-658 OWNER ALLOWANCES. (1) The owner allowances shall include all the personal benefits received from the provider or the related group. These benefits shall include, but not be limited to, the amounts paid for the personal benefit of the owner. These expenses to be disallowed as expenses and included in the owner allowances shall be:

(a) Pension - profit-sharing plans not provided for all employees.

(b) Life insurance including key-man insurance.

(c) Health and disability insurance not provided for all employees.

(d) Personal travel and transportation (actual or prorated expense of the motor vehicle).

(e) Personal expenses.

(2) Allowances shall include the assets and services of the facility used by the owner. These direct or prorated expenses to be disallowed as expenses and included within the owner allowance shall be:

(a) Depreciation (square footage).

(b) Real and personal property taxes (square footage).

(c) Utilities (square footage unless separately measured).

(d) Meals (total meals served).

(e) Plant maintenance (square footage).

(f) Laundry and linen (rate charged to private patients).

(g) Housekeeping (square footage).

NEW WAC 388-96-660 PRE-OPENING EXPENSES. (1) The one-time pre-opening expenses of a new facility incurred prior to the admittance of patients must be capitalized as deferred charges and amortized over not less than 60 consecutive months to be an allowable expense of the new provider.

(2) The amortization of the deferred charges shall begin in the first month the facility is available for patient care. These deferred charges shall include, but not be limited to, wages paid prior to the opening, construction financing, legal fees, organization expenses, feasibility studies, appraisal fees, etc.

NEW WAC 388-96-662 DISCRETIONARY ALLOWANCE. The provider will be entitled to a discretionary allowance which will be a fixed amount per patient day as determined by the department. (WAC 388-96-409.)

EW WAC 388-96-664 COSTS OF RELATED ORGANIZATION. (1) The cost of services, facilities, and supplies furnished to the provider by organizations related by common ownership and/or control (related organization) are not includable in the provider's allowable expenses.

(2) This general rule shall be waived if the provider and the related organization demonstrate by convincing evidence to the satisfaction of the department that:

(a) The related organization is a bona fide separate organization, and

(b) There is an open competitive market for the type of services, facilities, or supplies furnished by the related organization, and

(c) The services, facilities, or supplies are those which commonly are obtained by institutions such as the provider from other businesses, and are not a basic element of patient care ordinarily furnished directly to patients by such institutions, and

(d) The charge to the provider is at the cost to the related organization and is in line with the charge for such services, facilities, or supplies in the open competitive market and not in excess of the charges made under comparable circumstances to others by the related organization for such services, facilities, or supplies.

(3) When all of these conditions are met, the charges by the related organization to the provider for such services, facilities, or supplies will be considered allowable costs.

NEW WAC 388-96-666 RENTALS OR LEASES FROM RELATED ORGANIZATION. The expense of renting or leasing of a facility and/or equipment from a related organization shall be an allowable cost only to the extent that such rentals or leases and related property costs are at the cost to the related organization as modified by WAC 388-96-466, WAC 388-96-470, WAC 388-96-610 and WAC 388-96-664.

NEW WAC 388-96-668 SERVICE CHARGES FROM RELATED ORGANIZATION. (1) The service charges incurred by a provider from a related organization shall be an allowable cost only to the extent that such service charges are based on actual costs incurred by the related organization and do not exceed the price of a comparable service that could be purchased on the open competitive market.

(2) The provider shall submit a schedule of the actual costs incurred by the related organization in support of the service charges for, but not limited to, the following:

(a) Nursing supplies.
(b) Consultants.
(i) Nursing administration.
(ii) Medical records.
(iii) Restorative care.
(iv) Activities.
(v) Dietary.
(vi) Housekeeping.
(vii) Laundry.
(viii) Pharmacy.
(c) Maintenance and operation of plant.
(d) Administration and general.
(i) Administrator.
(ii) Assistant administrator.
(iii) Business office and accounting.
(iv) Management fee.

(3) The schedule shall specify the method used by the related organization in the allocation of these expenses to the provider. These service charges shall not include a mark-up or profit.

NEW WAC 388-96-700 APPEALS. (1) An appeal procedure is established to hear unresolved provider disputes regarding the prsopective and settlement rates, the cost reimbursement system, other principles, and rules and regulations issued by the department.

(2) In the appeal procedure, the provider shall first request a review of the initial exception by the department of social and health services, office of nursing home affairs. The request will bewritten, dated, and signed within 60 days after the initial determination by the department. The request must be filed with:

Office of Nursing Home Affairs M.S. 5-1
Cost Reimbursement Section
P. O. Box 1788
Olympia, WA 98504

(3) The supervisor will assign the exception request to a reviewer other than the one making the initial determination. The reviewer will consider new data and recommend a resolution to the dispute. This resolution will be final unless the provider determines that a conference is necessary to discuss and clarify the issue. If a conference is desired, an appointment will be made with the supervisor of the cost reimbursement section within 30 days of the notification of the second determination. Representation at the conference may include the provider and such other representation as desired to include, but not be limited to, an independent accountant, appropriate association representative, lawyer, etc. The results of theconference will be final unless a written request for a fair hearing, in accordance with the Administrative Procedures Act, RCW 34.04, is received by the office of nursing home affairs within 30 days from the date of the conference.

State of Washington
Department of Social & Health Services

(provider name
& address)

EXHIBIT G

MEDICAL ASSISTANCE
REMITTANCE AND STATUS REPORT

R/A NUMBER 5

PROVIDER NUMBER 199904 REPORT SEQ NUMBER 5 DATE 02/03/76 PAGE 1

PATIENT IDENTIFICATION		MEDICAL RECORD NUMBER	CLAIM NUMBER	SERVICE DATES FROM MMDD	YY	TO MMDD	YY	DAYS OR VISITS	PROCEDURE/ ACCOMMODATION CODE	TOTAL CHARGES	TOTAL ALLOWED	SALES TAX	NON-COVERED CHARGE & DEDUC.	PAYABLE CHARGES	REIM RATE	PAID AMOUNT	EXPLAINATION CODES
I.D. NUMBER	NAME																
CA 022118 B	[redacted]	10503	9875013015095	01 04	76	01 04	76	1 0	90000	10 00	6 85	00	00	6 35		6 35	001
CA 101146 A	[redacted]	10516	9876016020014	01 05	76	01 05	76	1 0	90000	10 00	6 85	00	00	6 35		6 35	001
CA 101146 A	[redacted]	10516	9876016020014	01 05	76	01 05	76	1 0	82482	3 20	2 70	00	00	2 70		2 70	001
			3					3 0		23 20	15 40			15 40		15 40	
FINANCIAL TRANSACTIONS		* STATE NUMBER	* CONTROL NUMBER	* SETTLEMENT PERIOD					* DATE APPLIED	* ORIGINAL AMOUNT	* CURRENT BALANCE		* AMOUNT APPLIED	* REMAINING BALALCE			
		AA714671	33466402						020376	525 40	327 13		15 40	311 73			
		AA714671	334664118						020376	525 40	311 73		100 00	211 73			
PENDING CLAIMS																	
RF 092546 A	[redacted]	10413	9876004017083	12 28	75	12 28	75	1 0	90000	10 00							3
RETURNED CLAIMS																	
CA 092151 A	[redacted]	10519	9876018016081	01 10	76	01 10	76	1 0	90000	10 00							024
CLAIMS PAYMENT SUMMERY		*CLAIMS PAID	*CLAIMS RETURNED					*DAYS	*CLAIMS AMOUNT	*WITHHELD AMOUNT			*NET PAY AMOUNT	*CREDIT AMOUNT		*NET 1099 AMOUNT	
CURRENT		2	1						15 40	15 40			00	00		15 40	
YTD		15	3						3175 20	213 67			2958 53	00		2958 53	

001; FEE ADJUSTED TO MAXIMUN ALLOWABLE
024: ELIGIBILITY EXPIRED PRIOR TO SERVICE DATE

EXHIBIT H

State of
Washington
Department
of Social & Health
Services

MEMORANDUM

May 17, 1976

TO: Physicians

FROM: Richard N. Nelson, Chief
Office of Medical Assistance

SUBJECT: CONTINUOUS CLAIM FORMS

Many physicians and their billing services have indicated a desire for a mechanically prepared physician claim form. Therefore, the following change in policy is announced. Effective April 1, the State of Washington will supply continuous claim forms for physician billing for those utilizing automated data processing for claims preparation. We encourage those of you who use automated data processing to work with us to develop the mutually economical method of card or tape transmittal of billed information. A special effort will be made during the first six months to convert as many billings into magnetic tape or computer card as possible. The continuous forms can be obtained by addressing a request to:

Professional Audit Unit
Attention: Claims Order Clerk
P. O. Box 2245
Olympia, Washington 98504

Continuous forms orders will be filled in lots of 15,000 per case based upon usage. Delivery time from order to receipt is estimated at 2 weeks.

If in the future the volume and usage of track mounted claim forms falls below the levels of economic production, the State may discontinue supplying these forms.

RNN:clu

HEALTH SERVICES DIVISION
John A. Beare, M.D., Director
MS 444, Olympia, WA 98504

EXHIBIT I

The $5 million swindle

EVERY YEAR Washington State taxpayers are robbed. Individually the thefts may not seem like much — a few dollars here, a few cents there — but taken together they add up to a loss of several million dollars.

Yet this is not the work of hoodlums, not the result of organized crime. These thieves don't carry guns or threaten violence. They weave instead a tightly-woven web of lies and deception designed to defraud the state's welfare programs.

Some are welfare recipients who conceal new cars and property, lie about job earnings and dependents, or hide other sources of income.

But other welfare cheaters may be doctors, ambulance companies, nursing homes, pharmacies, laboratories, and a wide variety of other medical vendors paid by the state to provide services for welfare clients. It's here that "the really big bucks" are probably involved, according to Charles Morris, secretary* of the Department of Social and Health Services which administers the state's welfare programs.

"We tend to assume that only poor people cheat," Morris says. "But the rich probably defraud at least as much as the poor, except that with the vendors the amounts involved are much larger." That's why the Department's Office of Special Investigation is beginning to take a hard look at the question of medical vendor fraud.

This special fraud unit has already had considerable success in uncovering cases of recipient fraud. Washington was one of the five most efficient states in catching and prosecuting welfare cheaters during fiscal year 1975.

During that twelve-month period the fraud unit found probable fraud in 1,089 of the cases investigated, according to Milton Burdman, deputy secretary of the Department of Social and Health Services. "This represents only about one percent of the 90,101 applications for financial assistance approved by the department during the same period," he says. "It also represents a significant amount of fradulently obtained funds to be recovered."

The Office of Special Investigation has actually turned out to be a pretty good investment for the state. It was set up by the legislature with an initial operating budget of $1.6 million for the 1973-75 biennium. This was used to staff the unit with 28 employees and set up six regional offices around the state.

Once the unit swung into action in August 1973, fraud cases started going to the county prosecutors at a record rate. By the end of the biennium in June 1975, the special unit had tracked down more than 2,000 cases of welfare fraud, involving more the $5 million.

That's quite a change from the second half of the sixties when prosecutors received a yearly average of only about 125 cases. Not that this means there is any more fraud now, according to Robert Neilson, director of the Office of Special Investigation. "We have no evidence that there is an increased amount of fraud," he says. "We're just catching more of it."

For one thing, back in the sixties fraud investigations used to be the job of the people responsible for administering the welfare programs at the local level — the same people who often approved the applications of recipients in the first place.

"A lot of information comes from neighbors who resent signs of affluence . . ."

But putting the responsibility for fraud investigations in one centralized unit is not the only reason why more welfare cheaters are being caught today. There's also something called the Verification Overpayment Control System.

**Effective August 1, Charles Morris will leave his position as secretary of the Department of Social and Health Services to take a job with the Vera Institute of Justice in London, England.*

This is a screening process which is used by all the department's local offices to verify the eligibility of applicants for welfare. "The idea is to catch potential fraud at the front door before the cheaters get on the rolls," Neilson says. "And it's doing a heck of a good job."

With the help of computer terminals and data processing techniques, employees in the local offices can determine with a push of the button whether someone has earned any unreported income or is already receiving welfare, social security, unemployment compensation, or other benefits. The department exchanges data with other state and federal agencies and has all of this to draw on when checking out a welfare applicant.

This control system also comes in handy in detecting cases of fraud among those already on the rolls. For one thing, the system's computers contain all the information gathered on recipients from the time they begin receiving grants. The information in these data banks follows recipients no matter where they move in the state and makes almost instant verification of their status possible.

Of course, this system does have its limitations, especially in cases where recipients set out to defraud the state by deliberately falsifying information. Such cases of hard-core criminal fraud are often uncovered as a result of tips provided by citizens. "A lot of our information comes from neighbors who resent signs of affluence when they know the people are on welfare," Neilson says. "They see a large new model car parked out front and they call us."

One kind of tip the special unit seldom follows up on is in "man in the home" cases. Neilson classifies this as a simple eligibility problem, not fraud. "We used to spend hours watching recipients' homes for evidence," he explains. "Other states, like Oregon, still conduct surveillance operations, but to me it's a waste of time, a luxury."

Instead, the state's local welfare offices have been told to reduce or take away grants in cases where they believe a man is living in the home or a recipient has claimed too many dependents. This means then that the burden falls on the recipients to prove otherwise.

The Office of Special Investigation is much more interested in tips which indicate that a welfare family is living beyond their means, that they have personal goods like a late model car which they couldn't conceivably afford and still be on welfare. If it looks like a case of possible or probable fraud, they conduct a thorough investigation.

Often however, the results vindicate the suspect. The fraud unit clears up more unfounded allegations than it finds cases of actual fraud.

"There's a difference between that and conscious fraud where the recipient comes in with false documentation and is trying to cheat you."

Call on the "hot line"

DURING the last session of the legislature, money was appropriated for a toll free "hot line" which will make it even easier for citizens to call in information about possible welfare fraud. Effective July 12, the number to call is (800) 562-6906.

While callers' anonymity is respected, Neilson likes to know their names so he can report back about results of investigations.

Sometimes the fraud unit discovers that an overpayment is the department's fault. Although Washington has the lowest overpayment rate of any metropolitan state in the nation, errors do occur. Other times it may be an honest misunderstanding on the part of a recipient. During fiscal year 1975, more than 80 percent of the cases investigated involved either unintentional error, mitigating circumstances, or no intent to defraud. But as Charles Morris says, "there's a difference between that and conscious fraud where the recipient comes in with false documentation and is trying to cheat you."

Just who are the one percent or so who do cheat? Neilson draws this profile of the welfare cheater: typically she's a woman, age 28, who has few skills, two or three children at home under age seven, and whose husband has deserted her. In many cases, she's failed to report income from a job."

"The tragedy is that if she declared the income, in most cases she could keep a good part of it because there are so many allowances," he says. "But she doesn't report it, and so she commits fraud."

When an investigation of such

a recipient has been completed, the fraud unit interviews her and explains her rights. If she doesn't agree with their findings, she can ask for a hearing to present her side of the case. "It's not a high-handed, arbitrary action," Neilson stresses. "We have to prove beyond a reasonable doubt that the intent to defraud existed."

But most of the time cases don't even get to court. "Seven out of ten times," he explains, "the recipient says 'Yes, I did it. Yes, I knew it was wrong. Yes, I shouldn't have, but I had to do something because the kids needed new shoes or something else.'

"Now what did they steal?" Neilson asks. "If they stole $2,000 we're going to send it to the prosecutor. If they stole $200, we're probably going to send it back to the local office and say establish a deduction on the grant until all of the money is paid back."

Whenever an overpayment of any kind is made — whether because of department error, recipient misunderstanding, or fraud — the person must still pay back the money. In fact, the state deducts up to ten percent of a recipient's future welfare payments each month until the bill is paid. During fiscal year 1975, for example, collection efforts were initiated for overpayments totaling some $2.3 million.

And if fraud is proven, recipients must pay back another 25 percent on top of what they stole. Washington is the only state in the union that doesn't trade dollar for dollar on welfare fraud. "If recipients had to pay back only what they took," Neilson points out, "that's an interest-free note and not a very good deal for the state." The 25 percent penalty also helps subsidize operation of the fraud unit.

When a recipient goes off welfare, the Department takes action to recover any money not already paid back. "When we say we've found $5 million worth of fraud, that doesn't mean we've turned that much money back to the state," he explains. "We've turned over to the State of Washington a *potential* for that much money. People *do* leave the state."

Often, though, welfare cheaters pay more than just a 25 percent fine for their crimes — many of them spend time in jail. Welfare fraud is a felony carrying a maximum 15-year prison term, and someone stealing even $1 could be prosecuted. Usually, however, the courts attempt to recover funds by deferring sentence and stipulating restitution.

"I can get an awfully lot more excited about jailing a medical vendor . . ."

Neilson questions the wisdom of sending many welfare cheaters to jail. "You don't gain much by putting the mother in jail, breaking up the home, putting the kids in foster care, and paying someone $200 a month to take care of them," he says.

The county prosecutors may also decline to prosecute recipients due to their age, physical or mental condition, language barriers, or a longtime lapse between when the fraud is committed and discovered.

Jail sentences for medical vendors who defraud the state are quite another matter, however. "I can get an awfully lot more excited," Neilson says, "about jailing a medical vendor who may be grossing $100,000 and is stealing out of greed, than I can a welfare recipient with three kids who's trying to make it on $300 a month."

In the few cases tried so far, the courts have also shown they are much more severe on the corporate offenders — the medical vendors like clinics, laboratories, and nursing homes which supply services to welfare clients.

"We've been trying hard to get some convictions," Neilson admits. "We want to let the industry know — and I'm talking about 15 to 20 different kinds of suppliers — that they're going to have to start abiding by the rules, that we're going to be very vigilant because there's so much money involved."

How effective the fraud unit will be in controlling medical vendor fraud in the future will depend to a great extent on the state's prosecutors, Neilson believes. They face a unique form of social pressure in such cases. "The prosecutors never play golf with welfare recipients or see them in a social situation, but they do see medical people, the laboratory owners and doctors socially," he says. "We will be really effective in this area of medicaid fraud only so long as this state's prosecuting attorneys are willing to prosecute."

Although the Office of Special Investigation has already investigated more than 60 cases of vendor fraud since February 1974, an expanded effort is now underway in this area. The legislature authorized hiring seven more employees for the 1975-77 biennium, specifically to be used in checking out medical vendor fraud.

To form procedural techniques for more effective medical vendor surveillance, Neilson's assistant Ron Crawford served as a consultant last year with the federal Department of Health, Education, and Welfare. "A task force approach is now being taken toward these investigations," Crawford says. "Teams of two or three employees each are becoming expert on fraudulent schemes used by vendors, ranging from nursing homes to clinical laboratories."

Vendor fraud cases involve a considerable amount of work. While an investigator may take up to 12 hours developing a case against a welfare recipient, it takes more than 72 hours to do the same thing on a medicaid vendor. The problem is paperwork — getting the vouchers and invoices, finding out what the state paid, and checking that against deposits made by the vendor.

But if the work is harder, it's also potentially more rewarding — at least financially. Right now the cost of providing medical benefits for the poor equals the cost of all the direct income maintenance grants like Aid for Families with Dependent Children (AFDC). "The thing that boggles my mind is the tremendous amount of money going into the medicaid field," Neilson says. "And our philosophy is that where there's money, there's bound to be a problem."

Fraud has been found in a number of cases investigated so far. Restitution of funds has been ordered in several of these and a few have even resulted in jail sentences.

For example, King County Superior Court found the vice president of one ambulance company guilty on four counts of petty larceny and sentenced her to 30 days in jail. The company had been altering trip tickets and sending false billings to the state for services not actually rendered. The court also ordered fines totaling $8,000 and restitution of another $226,000 to the state.

The same court sentenced an owner of a congregate care facility to 15 years, suspended to 60 days in jail, and ordered restitution to the state of $9,097. The facility had been billing the state for patients not even being cared for there.

Much of the fraud unit's work has been in the nursing home field, especially with cases involving misuse of patient trust funds. The state gives nursing homes $25 per month to be held in trust for each patient. But auditors from the Department of Social and Health Services (all nursing homes receiving state funds are now subject to periodic audit) discovered that instead of keeping the money in trust, the homes were using it to fund day-to-day operating expenses, make payrolls, and meet capital expenses.

One such "honest mistake" — the state couldn't conclusively prove fraud — resulted in the restitution of $17,000 for proper distribution to patient trust accounts. In another King County Superior Court case, a corporation owning six nursing homes pleaded guilty to embezzling patient trust funds and was fined $10,000. Of course, with the exception of fines the state doesn't really get any money back in such cases; it's all returned to the trust funds.

Investigations are more complicated now than in the days of the "ma and pa" nursing home; today they're big business. Neilson likens it to trying to fight an octopus, rather than a snake. "They trade records back and forth, and just about the time you think you've got your hands really on it," he says, "they sell out and the nursing home becomes a member of another large corporation."

"They trade records back and forth, and just about the time you think you've got your hands really on it, they sell out . . . "

Next on the list of medical vendors being investigated by the fraud unit are clinical laboratories. These came to Neilson's attention recently as the result of hearings held in New York City by the federal government which showed clinical laboratories grossly abusing the system.

Is it happening here? The fraud unit is about to find out. Investigators know exactly how much Washington paid each of these laboratories in 1974, and will be comparing that to what was paid out in 1975. If there's a marked increase, the laboratory will probably be audited to make sure everything's being done according to the rules.

One result of this investigation so far is that the fraud unit is planning to recommend some legislation. They've discovered few regulations here assuring professional performance of clinical laboratories. In Washington almost anyone can get into the business, while in some states laboratories can only be operated by doctors or those with certain degrees.

Other vendor fraud investigations underway involve pharmacies and doctors. For example, there's one pharmacy in this state which doubled its medicaid business from 1974 to 1975. Neilson wants to know why and has asked for an audit. There's also the case of a doctor who earned over $100,000 treating medicaid patients in the last two years. "Now that by itself is not a fabulous figure compared to doctors in other states," he says, "but the interesting thing is that the next highest doctor only earns $54,000. We're curious why."

Neilson states emphatically that he's not accusing the entire medical profession of cheating, any more than he's accusing all welfare recipients of cheating. It's a small percentage. "The people who are abiding by the rules have nothing to worry about. We're not pointing the finger at them," he says. "We just want to be able to say to the public, 'Yes, we're on top of this!'"

Eventually, he would like to see the various medical vendor professions police themselves. This has already happened in one case involving a chiropractor who took the state for about $90 in services never performed. Because the amount was so small, the prosecutor wouldn't touch it. But when the case was turned over to the disciplinary board of the chiropractors' association, they suspended his license for about 18 months — much more than the fraud unit could ever have accomplished. Unfortunately, Neilson says, he hasn't seen this same "sense of responsibility" displayed yet by the state's other medical societies.

And the Office of Special Investigation is not waiting for it to develop; this year they will be going ahead with their in-depth look at medical vendors. So far, Neilson believes they have only just scratched the surface in their investigations of vendor fraud.

Initially, the fraud investigators' aim was to catch the attention of potential violators. "That's why we've taken cases to court," he says. "That's why we've gotten jail time, and that's why we've gotten these tremendous fines."

The fraud unit makes sure that cases are well publicized whenever cheaters — either medical vendors or welfare recipients — are caught and punished. In Richland, for example, two people a week normally come in and want to be taken off welfare. But after a newspaper article appeared describing a welfare recipient's 15-year prison term for welfare fraud, it averaged 16 a day for a while. Is there such a thing as deterrence? "I don't know for sure," Neilson answers, "but that's pretty good evidence to me that there is."

Completely eliminating welfare fraud is undoubtedly too much to ask. "There's always a certain percentage who will try to cheat you," Neilson says. "We're always going to have the chiselers, the people who are really out to beat the system. It may take us a while," he concludes, "but eventually we'll nail them." Few people would disagree, considering the fraud unit's record so far. □

EXHIBIT J

PATIENT TRUST FUND ACCOUNTS

SUGGESTED BOOKKEEPING SYSTEM

PROVIDED BY
DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Exhibit J cont.

INTRODUCTION

Schedule IV of the Agreement for Skilled Nursing Care and Intermediate Care states in part, "The HOME agrees to provide and maintain, free of charge as a service to the patient, a bookkeeping system, adequate for audit, for all patient monies entrusted to and received by the HOME......"

This information packet is provided by the Department of Social and Health Services as an aid to the understanding and implementation of the requirement for such a patient trust bookkeeping system.

In an effort to aid the Home in an understanding of this requirement, each element of an adequate trust fund bookkeeping system will be explained; the area of the Agreement, RCW, WAC, or other authority requiring such element will be cited; and, where appropriate, models will be presented.

This model of bookkeeping system, as stated above, is provided as an aid to the Home. While this particular system need not be implemented, one very similar will be necessary to meet all the requirements of a trust fund bookkeeeping system which is "adequate for audit."

Therefore, we urge you to conduct a thorough review of your bookkeeping system. If it is not adequate for the needs of your patients and/or does not comply with all of the requirements as set forth in the Agreement, WACs, RCWs, or federal regulations, the home should replace it with this suggested system. If only a few areas of your system are weak, single elements of this suggested bookkeeping system can be used to supplement your system.

It is suggested all persons involved in any way with the patients' trust funds or charges to those funds read carefully Schedule IV of the Agreement, "Accounting for Personal Monies Entrusted to the HOME." This would include, but not be limited to, the owner, administrator, bookkeeper and Director of Nursing Services.

If this bookkeeping system or one very similar is implemented and all employees involved become familiar with the requirements, the result should be a system which is not only "adequate for audit," but one which better serves the needs of the home and the patients.

If questions arise concerning the Home's existing trust fund bookkeeping system or implementation of this suggested system, the Home should contact the Department Audit Section, Charles P. Woody, P. O. Box 1788, M.S. 51-1, Olympia, Washington 98504, or call (206) 753-2720, for advice and assistance.

Exhibit J cont.

ACCOUNTS, RECORDS AND PROCEDURES NECESSARY FOR ADEQUATE PATIENT TRUST FUND ACCOUNTING SYSTEM:

Account: 1. PATIENT TRUST FUND BANK ACCOUNT

- Each Home must maintain a bank trust checking account separate and apart from any other bank accounts of the Home or any other homes.

Records: 2. SEPARATE LEDGER ACCOUNTS FOR EACH PATIENT

3. PATIENT FILE CONTAINING:

   a. signed request to handle funds
   b. receipts and other documents supporting trust account balances
   c. denials for non-formulary drugs, physical therapy, equipment and/or other medical services not furnished by the facility but charged to the patient.

4. FILE FOR MAINTENANCE OF BANK STATEMENTS, CANCELLED CHECKS AND DEPOSIT SLIPS

Procedures: 5. FACILITY ADMITTANCE PROCEDURE TO INCLUDE:

   a. obtaining signed request to handle funds if requested by patient or authorized representative.

6. PROCEDURE FOR RECEIPT OF PATIENT TRUST MONEY

7. PROCEDURE FOR WITHDRAWAL OF PATIENT TRUST MONEY

8. PROCEDURE FOR APPLICATION FOR NON-FORMULARY DRUGS, PHYSICAL THERAPY, EQUIPMENT AND/OR OTHER MEDICAL SERVICES NOT PROVIDED BY THE FACILITY

- This should include filing of denial when received.

9. PROCEDURE FOR REFUNDING TRUST MONEY UPON TRANSFER, DISCHARGE OR DEMISE OF PATIENT

Reports: 10. FINANCIAL REPORTS TO PATIENTS

EXPLANATION OF THE ELEMENTS OF THE PATIENT TRUST FUND BOOKKEEPING SYSTEM

1. PATIENT TRUST FUND BANK ACCOUNT

Schedule IV (3) of the Agreement states in part: "The HOME further agrees that when the aggregate total of all patients' monies held in trust by the HOME is greater than $100, the amount over $100 shall be deposited in a bank trust checking account, separate and apart from any other bank account(s), of the HOME or other homes......"

This requirement precludes the possibility of a parent corporation or any other party maintaining the patient trust fund bank account for the Home. This responsibility belongs solely to the Home.

While a $100 trust petty cash fund is allowed, the Department strongly suggests that the Home use operating funds for petty cash and replenish this from the Trust Fund Bank Account when patients draw trust money from petty cash. This system greatly increases internal control over the trust fund as well as allowing a petty cash fund sufficient for the needs of the Home.

2. SEPARATE LEDGER ACCOUNTS FOR EACH PATIENT

Schedule IV (2) of the Agreement states in part: "The Home agrees to maintain a separate ledger account for each patient for whom the HOME holds money in trust. Each account and related supporting information shall be kept current, shall be balanced each month and shall show in detail, with supporting verification all monies received on behalf of the individual patient and the disposition of all monies so received. It is further agreed that each account shall be available for audit and inspection by a DEPARTMENT representative and be maintained for a minimum of three years......"

For informational purposes, the ledger sheets or cards should contain the name and type of patient, date entered, trust fund limit ($200 or $1500), date of charge or credit, source or use of money, and a running balance. (See sample Ledger Sheet - next page.)

RECOMMENDATION ONLY

Exhibit J cont.

SAMPLE

PATIENT TRUST RECORDS

LEDGER SHEET

Name ______________________________

Date Entered ______________________________

Type of Patient ______________
if M/R: Limit ______________

Date Mo./Day/Yr.	For/From	Ref.	Charge	Credit	Balance

3. PATIENT FILE

The patient's file should contain:

a. Signed Request to Handle Funds

Schedule IV (1) states in part: "The HOME agrees to provide and maintain......a bookkeeping system......for all patient monies entrusted to and received by the HOME for the patient who:

a) is incapable of handling his own money and whose guardian, relative, DEPARTMENT local office administrator or physician makes written request of the HOME to accept this responsibility......

b) is capable of handling his own money, but requests the HOME in writing to accept this responsibility."

The above requires the HOME to have on file, for any patient whose money the HOME handles, a request signed by the patient or his authorized representative. A suggested form is provided on page 6.

b. Receipts and Other Documents for Cash

Schedule IV (2) states in part: "Each account and related supporting information shall be kept current, shall be balanced each month and shall show in detail, with supporting verification, all monies received on behalf of the individual patient and the disposition of all monies so received. It is further agreed that each account shall be available for audit......and be maintained for a minimum of three years."

These supporting documents should either be kept in the individual patient's file or a separate file may be set up monthly for all patients' receipts and supporting documents for that month. There should be sufficient controls so that no documents are lost or misfiled.

c. Denials of Non-formulary Prescription Drugs, Physical Therapy, Equipment and/or Other Medical Services not Furnished by the Facility and Charged to the Patient's Trust Account

The "Drug Handbook and Index," under Rules Relating to Drugs, states in part: "NON-FORMULARY PRESCRIPTION DRUGS-MEDICAL CONSULTANT APPROVAL (1) Normal Requests. A request for non-formulary prescription drugs must be submitted by the attending physician to the local medical consultant for prior approval. The request must be to meet a medically mandatory condition supported by proper diagnosis and justification for the non-formulary drug."

This indicates only after the Department has denied payment for a non-formulary drug prescribed for a patient can the Home charge the

Exhibit J cont.

SUGGESTED FORM

REQUEST FOR HOME TO HANDLE PATIENT'S PERSONAL MONEYS

Date ______________________________

I, _______________________________________, request ________________________________
Patient or Authorized Representative (Circle One) — Nursing Home

to provide me a bookkeeping system for all moneys entrusted to or received by the Home for ____.
Patient's Name

CHECK APPROPRIATE BOX BELOW:

☐ I, ____________________________________, Authorized Representative of the above named patient, am responsible for the management of patient's trust moneys. I understand these moneys are to be used for the benefit of the patient only and are subject to audit at any time by the Department of Social and Health Services.

☐ ____ is responsible for the management
(Nursing Home)
of the trust moneys of the above named patient.

____
Patient

____
Authorized Representative

____
Nursing Home Administrator

patient's trust account. Any charges to patient trust accounts for non-formulary prescription drugs must be supported by a denial from the Department. The Department suggests the Home require the pharmacist to forward the denial with any pharmacy bills for non-formulary prescription drugs before the bill will be paid.

The Agreement (10) states in part: "It is mutually understood and agreed that the HOME may charge patients for the below-listed personal incidental items, supplies or services furnished by the HOME as needed by or at the request of the patient...... c. Exclusive use of equipment such as walker, wheelchair, crutches only when the DEPARTMENT is unable to supply the particular equipment on a loan basis." (Underlining supplied.)

The above forbids charging a patient for equipment purchase or rental unless "the DEPARTMENT is unable to supply" the equipment. Again, a denial from the Department should be on file to support any such patient trust charges.

4. FILE FOR MAINTENANCE OF BANK STATEMENTS, CANCELLED CHECKS AND DEPOSIT SLIPS

Schedule IV (3) of the Agreement states in part: "......The related bank statements, checkbook, check register and all voided and cancelled checks shall be made available for audit and inspection by a DEPARTMENT representative, and shall be maintained by the HOME for not less than three years......"

5. FACILITY ADMITTANCE PROCEDURES TO INCLUDE

a. Obtaining request to handle funds.

The Home should have on file for each patient for whom the Home maintains a trust account a written request signed by him or his authorized representative directing the Home to handle his money. (See 3 (c) above.)

6. PROCEDURE FOR RECEIPT OF PATIENT TRUST MONEY

a. When moneys are received, a receipt should be filled out in duplicate; one copy should be given to the person making payment or deposit, and the other copy should be retained in the receipt book for easy reference.

b. Checks received by patients must be endorsed by the patient. Schedule I-A (6e) of the Agreement states in part: "Each patient receiving a check or state warrant is responsible for endorsement by his own signature. Only when the patient is incapable of signing his name may the HOME assume the responsibility of securing the patient's mark "X" followed by the name of the patient and the signature of two witnesses."

c. Moneys received by the Home for a patient's trust account (personal and incidental care allowance) must be deposited to the Patient Trust Fund Bank Account within one week. Schedule IV (3) of the Agreement states in part: "......Cash deposits of patient allowances must be made to the trust account within one week from the time that payment is received from the Department, Social Security Administration or other payor......"

   If both the general fund account and the trust fund account are at the same bank, the trust portion of checks which include care payments can be deposited directly to trust by including a trust account deposit slip for the correct amount with the checks and the general account deposit slip.

d. The patient's trust account ledger sheet must be credited with the allowance received. This should be referenced with the receipt number and must be supported by a copy of the deposit slip (one copy for all deposits made).

e. When a patient's income changes

   - The home should notify the Economic and Social Services Office immediately. WAC 388-88-090 RECEIPT OF SUPPLEMENTAL COMPENSATION FOR NURSING HOME CARE states in part: "(1) A nursing home learning of a possible resource or income which would result in a contribution or increased contribution toward the total cost of care of a patient shall report such information to the department, i.e., the caseworker in charge of the case."

   - Since any additional income will serve to decrease the state's participation, the Home should deposit the normal amount in the trust account and the balance of care, with a notation on the patient's general ledger card "pending award letter - change in income."

7. PROCEDURE FOR WITHDRAWAL OF PATIENT TRUST MONEY

   a. Patient Request for Cash

      1. Trust Fund Petty Cash
         - pay patient from petty cash
         - obtain signed receipt for cash
         - maintain all receipts with petty cash until fund is replenished
         - replenish fund for exact amount used as per receipts, and post the receipts to the patients' individual ledgers
         - the receipts can be attached to the check stub to substantiate the trust account withdrawal
      2. General Fund Petty Cash
         - same as for trust fund petty cash, except replenish from trust account for trust disbursements and from general account for general disbursements

3. Any petty cash fund used should be an imprest fund; that is, there should be a predetermined amount (e.g., $100.00) for the fund. As money is withdrawn, receipts are issued and at all times the amount of money plus the amount of the receipts should equal the predetermined amount (for example, $86.97 plus receipts totalling $13.03). This type of system greatly increases internal control over cash.

b. Patient Request for Goods/Services

1. Obtain receipt for money to purchase goods/services signed by patient
2. Charge patient's trust ledger account
3. Retain receipt to support ledger balance (with patient's name)

c. When Patient Does Not Have Sufficient Money in Trust to Meet His Request

Schedule IV (2) of the Agreement states in part: "No patient account may be overdrawn (show a debit balance). If a patient wants to spend an amount greater than in such patient's trust account, the HOME may provide money from its own funds and collect the debt by installments from that portion of the patient's allowance remaining at the end of each month. No interest may be charged to patients for such loans."

d. Inappropriate Charges

Any persons involved in the origination, posting or payment of a trust charge should be aware of what constitutes an inappropriate charge. This is spelled out in different areas of the Agreement and WACs. Any questionable charge should be investigated before payment. The Audit Section is available for advice or assistance, if needed.

e. As an alternative to having individual receipts signed, the Home can have a sheet for Trust Withdrawals indicating date, patient's name, item purchased, amount, and authorizing signature (patient or authorized representative). This does not preclude maintaining receipts for goods and services as support for trust balances.

8. PROCEDURE FOR APPLICATION

a. Non-formulary prescription drugs (See 3 (c) above.)

b. Physical and/or speech therapy

WAC 388-86-090 states: "(1) Physical therapy, other than that provided in a hospital as part of inpatient treatment, may be authorized within the availability of funds only when such therapy:

(a) Will avoid the need for hospitalization, or
(b) Will reduce the length of stay of a recipient in a nursing home, or

(c) Will assist the recipient in becoming employable, or
(d) Is medically indicated in unusual circumstances and is requested by the attending physician and concurred with by the medical consultant.

(2) Physical therapy must be performed by a registered physical therapist and must have prior approval by the local medical consultant.

(3) Speech therapy, as an adjunct to necessary treatment of a medical or remedial condition for which the department has assumed initial responsibility, may be authorized subject to the availability of funds and:

(a) the treatment must have prior approval by the local medical consultant,
(b) the fee for service must be agreed to in advance of therapy,
(c) the therapy must be performed by a speech pathologist or audiologist who has been granted the certificate of clinical competence by the American Speech and Hearing Association, or who has completed the equivalent education and work experience necessary for such a certificate,
(d) the Department reserves the right to limit the number of treatments based on professional judgment."

Therefore, a patient's trust account should not be charged for these services unless a denial is on file.

c. Equipment (See 3 (c) above.)

In all cases, a denial from the Department should be on file before a patient's trust account is charged for any of the above services.

9. PROCEDURES FOR REFUNDING TRUST MONEY

Trust money is exempt income and cannot be applied by the Home to a patient's outstanding care bills.

a. Upon Discharge: The balance of a patient's trust account will be paid to him from the Patient Trust Bank Account and a receipt should be obtained for that amount.

b. Upon Transfer: When a patient is transferred, the balance in his trust account, less any amount owing the Home for trust charges, will accompany the patient to his new residence. (In some cases it may be well to mail refund to new residence.)

c. Upon Demise: The Home will obtain a receipt from next of kin, guardian, or duly qualified agent when releasing the balance of money held in trust. If there is no identified next of kin, guardian, or duly qualified agent, the ESSO is to be contacted for assistance in the release of the money held in trust. A check or other document showing payment to such next of kin, guardian, or duly qualified agent will serve as a receipt.

10. FINANCIAL REPORTS TO PATIENTS

Department of Health, Education, and Welfare; Standards of Participation; Chapter III--SOCIAL SECURITY ADMINISTRATION, DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE; PART 405--FEDERAL HEALTH INSURANCE FOR THE AGED AND DISABLED; Paragraph 1121--Condition of Participation--governing body and management, states in part:

"(k) Standard: Patients' rights. The governing body of the facility establishes written policies regarding the rights and responsibilities of patients and, through the administrator, is responsible for development of, and adherence to, procedures implementing such policies. These policies and procedures are made available to patients, to any guardians, next of kin, sponsoring agency(ies), or representative payees selected pursuant to section 205 (j) of the Social Security Act, and Subpart Q of Part 404 of this chapter, and to the public. The staff of the facility is trained and involved in the implementation of these policies and procedures. These patients' rights policies and procedures ensure that, at least, each patient admitted to the facility:......(6) May manage his personal financial affairs, or is given at least a quarterly accounting of financial transactions made on his behalf should the facility accept his written delegation of this responsibility to the facility for any period of time in conformance with State law."

Department of Health, Education, and Welfare, Standards of Participation; Chapter II--SOCIAL AND REHABILITATION SERVICE (ASSISTANCE PROGRAMS), DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, MEDICAL ASSISTANCE PROGRAM; PART 249--SERVICES AND PAYMENT IN MEDICAL ASSISTANCE PROGRAMS; PARAGRAPH 12--Standards for intermediate care facilities states in part:

"(a) The standards for an intermediate care facility (as defined in § 249.10(b)(15) of this part) which are specified by the Secretary pursuant to section 1905 (c) and (d) of the Social Security Act and are applicable to all intermediate care facilities are as follows. The facility:

(1) Maintains methods of administrative management which assure that:

......

(ii) There are written policies and procedures available to staff, residents and the public which:

......

(C) Provide for the registration and disposition of complaints without threat of discharge or other reprisal against any employee or resident.

(iii) A written account, available to residents and their families, is maintained on a current basis for each resident with written receipts for all personal possessions and funds received by or deposited with the facility and for all disbursements made to or on behalf of the resident:......"

Exhibit J cont.

WACs, RCWs, and Federal Regulations Included:

WAC 388-42 Funeral Expense

-030	Eligibility Standards
-040	Resources Considered
-050	Veterans' Burial Benefit
-080	Railroad Retirement Death Benefit
-090	Life Insurance
-100	Decedent's Estate
-110	Interment of Two or More Bodies in One Grave

WAC 388-86 Medical Care--Scope and Content of Care
(See 388-86--pl for Paragraph Titles)

WAC 388-87 Medical Care--Payment
(See 388-87--pl for Paragraph Titles)

WAC 388-88 Medical Care--Nursing Home Care
(See 388-88--pl for Paragraph Titles)

WAC 388-91 Medical Care--Drugs

-010	Drugs-Persons Eligible
-013	Physician's Name Required on Prescriptions
-016	Limitation to Payment
-020	Nonformulary Prescription Drugs--Medical Consultant Approval
-030	Prescription Form 6-02(5889)

RCW 63.28 Uniform Disposition of Unclaimed Property

Department of Health, Education, and Welfare
Standards of Participation
-Skilled Nursing Facilities
-Medical Assistance Programs

EXHIBIT K

WORKING PAPERS
RCW ___________
SUMMARY OF CONCERNS

Facility Name ______________

Vendor Number ______________

Prepared By ______________

Date ____________________

Cost Center	Number		Account Title	Dollar Adjustment	Code (see below)	Explanation of Adjustment
	Page	Line				

Code: A - Addition Error
B - Improper Classification of Expense
C - Improper Classification of Income
D - Non-participating Costs as Defined by C.R.M.
E - Annual Report Does Not Reconcile to General Ledger
F - Other (Specify in detail)

Exhibit L

DSHS LABORATORY REVIEW GUIDE

PURPOSE OF THE GUIDE

This guide is intended to provide a structured process for reviewing claims submitted for laboratory services. It will provide an audit review capability to detect certain improper billing practices which may in turn be indicative of potential fraud or abuse. It is important for the reviewer using the guide to follow these procedures and not expand the review even if additional review appears warranted. Additional investigation will be directed by the supervisor. However, the guide does leave latitude so that discretion and individual judgment on the part of the reviewer can and should be exercised.

OVERVIEW OF THE LABORATORY REVIEW GUIDE

There are four major steps involved in conducting the review. Below is a brief description of each:

Step I - Preliminary Review

The preliminary review has two broad features:

A. to develop a knowledge of the DSHS regulations and guidelines and claims processing system for reimbursing laboratory services (Form LAB-1);

B. to develop profile information regarding the laboratory selected for review (Form LAB-2) and then to select provider claims to:

1. review against the DSHS regulations and guidelines, and
2. use in performing later phases of the review (LAB-3 and partial completion of LAB-4).

Step II - Field Review

The field review consists of visiting the laboratory selected to secure documentation necessary to support later findings. There are four primary areas of activity:

A. document selection and photocopying;
B. inventory of lab equipment (Form LAB-5);
C. interview with lab director (Form LAB-7);
D. "mimi review" of findings for completeness (Form LAB-6).

Step III - Desk Review

The desk review consists of:

A. verifying physician's lab orders (Form LAB-8);
B. reviewing documentation to measure potential abuse on a claim by claim basis (Form LAB-9);
C. combining and summarizing the individual claims information (Form LAB-10).

Step IV - Completing the Review

This step involves a summary report of findings (Form LAB-11) related both to the individual claims selected for review as well as overall findings resulting from the inventory of lab equipment and interview.

Instructions for Carrying Out the Full Review

Step I - Preliminary Review

Part A - Familiarization with DSHS Program

Task 1. An individual on the State's Medicaid staff knowledgeable about laboratory reimbursement and claim processing should be identified to serve as liaison for the review team. This person should be available to respond to questions regarding procedures and interpret policy.

Task 2. Identify any operating guides detailing specific methods of adjudicating claims for laboratory services. Additionally, any policy issuances, instructional materials furnished to participating laboratories, or other materials pertinent to the way the Dept. has determined laboratory services will be reimbursed should be identified and reviewed.

Task 3. The information obtained from the analysis performed in tasks 1 and 2 will be used to complete the "Preliminary Review Questionnaire" (LAB-1). (NOTE also the instruction sheet which accompanies LAB-1.) This form may be completed in part as a result of the reviewer's own analysis of pertinent DSHS documents. However, the reviewer should review the results of that analysis with the Medicaid office liaison person for comment on the accuracy of the information recorded and to secure any information called for by LAB-1 but not evident from review of DSHS instructional materials.

Part B - Selection and Review of Materials Related to the Individual Laboratory (Completion of forms LAB-2 and LAB-3)

Task 4. If the providers to be reviewed are to be selected by the review team, the claims processing supervisor should be requested to furnish statistical detail needed to select providers.

Task 4a. After selecting a provider for review, the reviewer will obtain the latest copies of the Department's independent laboratory survey report (OMB No. 72-R0827) and the annual laboratory registration (no form number assigned). Copies of the above reports may be obtained from the laboratory section, Health Services Division, 1409 Smith Tower Building, Seattle, Washington 98104.

Task 5. To be identified later.

Task 6. To be identified later.

The claims processing supervisor should also be asked about correspondence files or other files established for the laboratory which may be helpful in building the profile report. Following completion of Task 4a the reviewer should have the necessary information to complete Part I of LAB-2.

Task 7. Billing Information

Claims processing should be requested to pull the laboratory billing information for the period under review. This profile should list recipient, recipient number, service performed, date of service, amount billed, and amount paid. The report should also give aggregate information on total dollars, number of recipients, and number of services. The reviewer may have to work with less than optimal information. On the other hand the MMIS system may have detail not specifically identified above, but which may be pertinent profile data. In either case, reviewer descretion will be required in completing the "Other Information" section of Part II of LAB-2 to assure that pertinent provider billing information is supplied to the extent it is available.

Task 8. Claims Selection

The next phase to the preliminary review is to select individual claims to be audited. The reviewer will do this on a random basis, selecting 25 line items off the provider profile which will ultimately be audited through the field and desk review. (Steps II and III)

A request will then be made for each individual claim to be pulled. The reviewer will prepare a listing of the claims selected for review (Columns (1), (2), and (3) of LAB-3). The top portion of column (1) of LAB-4 (Claims worksheet) will also be completed.

SUMMARY

Following partial completion of the claims worksheets, the reviewer has performed all of the tasks required for the Preliminary Review (Step I). At this point the reviewer should have:

1. a good working knowledge of the DSHS processes for determining and assuring that a laboratory is qualified to participate in the Medicaid program;
2. an understanding of DSHS methods for paying claims for laboratory services and special policies governing reimbursement;
3. specific information on the laboratory selected for review relating both to qualification to perform services and billing volume;
4. detail on specific claims which will be audited.

Step II - Field Review

The Reviewer will need the following documents to conduct this portion of the review:

1. two copies of the Laboratory Claims Selection List (LAB-3);
2. the batch of Claim Worksheets (LAB-4);
3. a blank copy of the Laboratory Equipment Survey Report form (LAB-5);
4. a blank copy of the Laboratory Data Collection Checklist (LAB-6);

5. a blank copy of the Lab Director/Interview Guide (LAB-7);
6. the batch of copies of the original Medicaid claims.

The reviewer should not need to use the Claim Worksheets (LAB-4) or the claims themselves (items 2 and 6 in the list above) while in the laboratory unless the lab director refuses to allow copies of the Medicaid records to be made. If the director does refuse, the claims and Claim Worksheets will be needed so that the review can be conducted on the laboratory premises.

Section 1400 of the Physician Review Guide should be reviewed for suggested information on the approach to scheduling appointments and explaining the purpose of the review to the laboratory director. Also before visiting the laboratory, the reviewer should refer to Section 1441 of the Physician Review Guide and Section 3441 of the Pharmacy Review Guide for a full discussion of issues which may come up during contact with the director and suggested reviewer responses.

Task 9. Once at the laboratory, the reviewer should furnish a copy of LAB-3 (Claim Selection List) to the lab director so that patient laboratory service records can be pulled. An important reminder: Be certain that the laboratory director agrees to allow access to his records before furnishing him with a copy of LAB-3. The reviewer should also be certain the director understands that strict rules of confidentiality will be followed and the photocopied records will be used only to conduct the review.

The reviewer should advise the director that several questions will need to be asked of him and his billing clerk regarding the laboratory operation, and determine his preference in conducting the interview before or after photocopying documents. The director should also be told that an inventory of his laboratory equipment must be performed and that it is necessary to have him or a selected member of his staff identify the equipment and describe its use.

Part A - Document Selection and Photocopying

Task 10. Once the lab service records are pulled, the reviewer may begin photocopying the documents. After they have been copied each should be reviewed with the director to be certain all entries are legible. The important information to be obtained from each record is:

1. the patient's name;
2. the ordering physician or nursing home;
3. the test that was ordered and the date;
4. the test that was performed and the date;
5. the notation of test results and the date test results were referred back to the ordering physician or nursing home;
6. the person who performed the test;
7. any pertinent notes made by laboratory personnel.

If items of this information are not on the document selected for photocopying but are elsewhere in the lab's records, request that the appropriate document be pulled for additional copies to be made.

Task 11. The reviewer must also request and copy the laboratory price list(s). The laboratory may offer discounts for volume or for other reasons. If this is the case, be certain that the reason for discounts is explained and that each price list is copied.

Part B - Inventory of Laboratory Equipment

Task 12. The laboratory's capability to perform certain tests and the reimbursement levels judged appropriate by DSHS may be partially dependent on the equipment in use. For this reason, it is important for the reviewer to inventory the major items of equipment in use and receive an explanation of their testing capability. Laboratory Equipment Survey Report Form LAB-5 is used for this purpose.

Although the complex nature and capability of the equipment may not be fully understood by the reviewer, the description offered by the director should be sufficient documentation. If, however, the reviewer has reason to believe that the laboratory is billing for more sophisticated testing than the equipment capability would indicate, he should advise the director that it will be necessary for a lab specialist to complete that portion of the review. Some indicators of a lab overstating its capability might be:

1. Simplistic equipment is observed but high priced tests are being billed for.

2. There is a long delay for sophisticated tests from the time the test is ordered before the results are returned. (This may imply that the specimen is sent to a reference lab for testing.)

Part C - Interview with Laboratory Director

Task 13. The reviewer will need to determine how the laboratory operates and its methods for submitting billings to Medicaid. This is done through completion of Laboratory Director Interview Guide (LAB-7). The questions on the form are self explanatory.

Part D - Mini Review of Findings

Task 14. It should be noted that the order of the field review may not be identical to the process as outlined in parts A through D of Step II. The sequence of performing these necessary functions may be altered depending on the wishes of the lab director and the convenience of his schedule.

Regardless of the sequence of performing parts A through D, after these necessary tasks are done, the reviewer should take a few minutes and review the information for completeness. At this time, the reviewer will complete the Laboratory Data Collection Checklist (LAB-6). A "mini-review" should be done at this time to ensure:

1. that photocopied documents are legible
2. that all pertinent questions are satisfactorily answered on the interview guide;

3. that discrepancies noted which should be brought to the attention of the lab director are identified.

   NOTE: Caution should be exercised in discussing discrepancies with the director. If fraud or abuse is identified as a result of the discrepancy, the reviewer will not want to confront or accuse the director or his personnel.

If additional information or explanation is required the reviewer should ask for it at this time.

Step III - Desk Review

The reviewer should have before him the following documents:

1. copies of all relevant laboratory records including documentation of all items noted in Task 10 and the laboratory price list(s);
2. the batch of copies of the original Medicaid claims;
3. the batch of Claim Worksheets (LAB-4);
4. the Laboratory Claim Selection List (LAB-3);
5. a blank copy of the Prescriber Contact Sheet (LAB-8);
6. a completed copy of the Laboratory Equipment Survey Report Form (LAB-5);
7. a completed copy of the Laboratory Director/Interview Guide (LAB-7);
8. the completed Laboratory Profile Report (LAB-2);
9. a report on the DSHS methods for assuring proper payment for lab claims (Response to questions on LAB-1);
10. the completed Data Collection Checklist (LAB-6)

NOTE: If the reviewer notes that some of the above information is not completed, full documentation should be secured before beginning the desk review.

Part A - Verification of Physician's Lab Orders

Task 15. The reviewer should now fill out columns (1), (2), and (3) of Prescriber Contact Sheet (LAB-8) by recording the information from the Claim Selection List (LAB-3). The reviewer should then verify by telephone contact, that the prescribing physician did, in fact, order the lab test in question. If ten or more claims have been ordered by the same physician, the reviewer should consider visiting rather than calling the physician in order to obtain the necessary information. The reviewer should telephone for an appointment if such a visit is necessary.

At this time, reference should be made to Section 3462 of the Pharmacy Review Guide for suggested information on the approach to contacting the ordering physician. The words "laboratory test" should be used in place of "prescription." Also the reference to Schedule 4 in the Pharmacy Review Guide should be replaced by LAB-8.

Part B - Reviewing Documentation to Measure Potential Abuse on a Claim by Claim Basis

The reviewer is now to determine whether the documentation supports the billing for each of the claims selected for review, or if there are discrepancies which represent potential abuse. This is done by completing Potential Abuse Measurement (LAB-9). On LAB-9, types of potential abuse are broken into three categories: Service Verification, Test Performance, and Charge Patterns. An explanation of each category and the instructions for completing LAB-9 follows:

Part I of LAB-9 - Service Verification

Task 16. The purpose of this portion of LAB-9 is to note whether any lab test was supported by documentation (line 1), and if so, whether the service documented was the same as that billed for (line 2). Furthermore, since laboratories can only legitimately bill Medicaid for tests ordered by a physician, line 3 is intended to record whether in fact the documentation supports the test being so ordered. Lines 1a, 2a, and 3a relate to the preceding three lines and require that the reviewer indicate a dollar amount in the appropriate space when any one of the three types of potential abuse is noted.

As an example of the way this portion of the form should be completed, if the laboratory has been unable to support the claim with any record of a lab service being performed, N would be entered in the result column of line 1. Line 1a would be used to record the dollars involved in the abuse. In much the same way, lines 2 and 3 may be filled out, with respective dollar entries on lines 2a and 3a. Line 4 requires the reviewer to fill out the dollar amount of the service actually provided. If the claim has been verified, then the dollar amount should be the amount claimed. Conversly, if there is no verification, the entry should be "$0".

Part II of LAB-9 - Test Performance

Task 17. The purpose of Part II is to determine whether or not the lab test in question was performed in a properly certified laboratory (line 5), by properly qualified personnel (line 6) and with equipment capable of properly performing the specific procedure (line 7). It is possible that some of the information may not be available to the reviewer. If so, indicate by N/A in the Result column. Otherwise, enter a "Y" or "N" much as was done for Part I.

Lines 5a, 6a, and 7a relate to the preceeding three lines and require that the reviewer indicate a dollar amount in the appropriate space when any of these three types of abuse are noted. As an example for this part, if DSHS regulations require a pathologist to perform the test in question, but the reviewer finds that it had been performed by an unqualified lab technician, the reviewer should enter an "N" in line 6 and enter the amount of the claim in line 6a.

Part III of LAB-9 - Charge Pattern

Task 18. Part III focuses on the different ways a laboratory might submit a claim for an amount for service greater than the amount the laboratory is entitled to. These abuses are as follows:

- billing for individual tests where multiple testing was performed (line 8);
- billing for an amount above the usual and customary charge (line 9);
- billing an amount greater than was charged by the lab to which the specimen was referred and the test subsequently performed (line 10);
- billing more than once for the same service (line 11).

Just as for the previous parts of LAB-9, lines 8a, 9a, 10a and 11a refer back to the previous four lines, and require the reviewer to indicate a dollar amount in the appropriate space when any of these types of abuse are noted. For example, if it has been determined that a laboratory is guilty of duplicate billing for a service for which an $8 claim was submitted, the reviewer should indicate this with a "Y" in the Result Column in the row corresponding to question 11, and enter $8 in the row corresponding to question 11a. Similarly, should the reviewer determine that this $8 test was performed, but as part of a multiple test procedure for which allowable reimbursement is only $5, then a "Y" should be entered opposite question 8, and $3 (the difference between the amount billed and the proper reimbursement) should be entered opposite question 8a.

Part IV of LAB-9 - Totals

Task 19. Finally, in Part IV "Totals", the reviewer compiles all the information calculated above to make a final determination regarding the amount, if any, of potential abuse connected with the individual claim. Line 12, "Total not classified as potential abuse", is calculated by subtracting any potential abuse found in lines 5a-11a from the amount of line 4. Line 13, "Total amount of potential abuse", is determined by subtracting the amount on line 12 from the amount claimed. Line 14 is merely to indicate if in fact any potential abuse was detected. If line 13 indicates any amount other than $0.00, then a "Y" should be indicated on line 14.

Part C - Summarizing Incidence of Potential Abuse

The reviewer must now summarize the results of the findings on each individual claim under review. This is done by taking pertinent information off each LAB-9 and entering the information on LAB-10 (Laboratory Review Summary). Completed, LAB-10 will provide a total overview of the provider billing practices based on the documentation results of the claims selected for review.

Part I of LAB-10 - Totals of Individual Potential Abuses

Task 20. The reviewer records by type of abuse the number of claims and dollar amounts involved in columns (4) and (5).

Part II of LAB-10 - Totals of Potential Aubses

Task 21. The reviewer totals the number of claims and dollars involved in performing the Part I calculation and enters the result next to the appropriate line item in columns (4) and (5).

Part III of LAB-10 - Totals of Sampled Claims

Task 22. The reviewer enters the total number of claims selected for review in column (4) and the total amount paid on all the sampled claims in column (5). (Derived from totaling the "amount paid" entries from Claims Work Sheets (LAB-4).

Part IV of LAB-10 - Ratios

Task 23. Record in column (4) the percentage of the number of claims indicating potential abuse to the total number of claims. Enter in column (5) the percentage ratio of dollar amount of potential abuse to total amount paid on all claims.

Step XV - Completing the Review

Task 24. The final step in the review process is the completion of the Provider Review Summary Report (LAB-11). The report summarizes the overall findings of the review and presents certain additional identifying data about the provider as well as a detailed tabulation of all review findings.

The report is in two sections. Section I, "Identifying Information" is self explanatory. Section II "Provider Characteristics", is intended to focus on:

a. provider type infromation available. From Laboratory Director Interview Guide (LAB-7);

b. organization/ownership of provider: also available from Laboratory Director Interview Guide (LAB-7);

c. estimated proportion of revenues from medicaid, estimate from provider or determined from provider records;

d. total medicaid payments in most recent calendar quarter. Available from Laboratory Profile Report (LAB-2);

e. program enrollment: available from Provider Profile.

LAB-1: PRELIMINARY QUESTIONNAIRE FOR LABORATORY REVIEW

1. What are rules for reimbursement related to multiple tests from one sample?

2. Have separate reimbursement schedules been developed for individual versus multiple testing? If so, please obtain a copy.

3. Does DSHS have rules relating to duplicate tests performed by more than one laboratory or by physician and laboratory? Explain.

4. Must laboratories bill directly for all services performed or may the ordering physician bill? If the laboratory must bill directly, how does DSHS assure compliance?

5. In the case of an independent laboratory billing, what procedure does DSHS use to assure that the test was ordered by a physician?

6. What coding system is used to bill for laboratory services?

7. Does DSHS have a procedure for determining if the test billed for was done by a laboratory? Explain.

8. Is there a screening mechanism to identify irregular billing practices? Explain.

9. What is the procedure for handling what appears to be irregular billing practices? Explain.

10. Other Comments:

INSTRUCTIONS FOR LAB-1

LAB-1 is designed to familiarize the reviewer with DSHS procedures and requirements and should be compiled before the reviewer begins the field review. It need be completed only once for the first review, not before each laboratory visited.

Questions 1 and 2 concern the problems of multiple testing and the Dept. regulations regarding reimbursement. Question 1 relates to the general rules for reimbursement for multiple testing from one sample. Certain procedures may be accomplished by a single machine at the same time. Because of efficiency, accuracy, etc., the Dept. may require certain tests to be performed either by multiple testing or individually. Any other pertinent information regarding multiple testing should be compiled.

Question 2 is really a subpart of Question 1 and deals with different reimbursement schedules, if they exist, for individual as distinguished from multiple testing. The multiple testing procedures may cost a fraction of that for each procedure done separately. A Dept. may distinguish reimbursement for a procedure depending upon whether it was done individually or as part of a multiple test.

Question 3 is directed to any Dept. regulation regarding duplicate tests by more than one laboratory or by a physician and a laboratory. A Dept. may limit reimbursement for laboratory procedures to the initial procedure and will not accept billing for a follow-up test by a laboratory after the physician or a different laboratory has performed the tests.

Question 4 refers to a regulation which may vary among Depts., and could greatly affect the entire laboratory review process. In some Depts., the laboratory, and only the laboratory, may bill Medicaid for laboratory services. However, should a Dept. allow the ordering physician to bill Medicaid (after the physician has been billed by the laboratory) proper laboratory review may require coordination with the physician review in order to properly trace the laboratory billing practices.

Question 5 also deals with the relationship between the laboratory and physician. The issue directed here is the Dept 's ability to monitor whether a laboratory test was in fact ordered by a physician and how this is done.

Question 6 asks for a description of the coding system for reimbursement for laboratory services. This information will probably be necessary for the reviewer in interpreting provider profile and other statistical information.

Question 7 focuses on the situation where one laboratory has sent out work to another for any of various reasons (e.g., lack of proper equipment, personnel, time, etc.). Proper monitoring of laboratory procedures would include determinations of which laboratory did in fact perform the work to ascertain if the procedure was performed by a certified lab, qualified staff, and on proper equipment. In addition, determination that another lab performed the test may have an impact on the amount claimed.

Questions 8 and 9 refer to the identification and handling of irregular billing practices. Knowledge of the Dept's capability to screen and react to such practices is necessary to adequately understand the Dept's. claims processing system.

INSTRUCTIONS FOR LAB-2

The information required for completing LAB-2 may be compiled at any time up until and during the desk review. However, it may be advisable to complete the form before the field review as a sensitivity to the nature of the particular laboratory may be helpful in completing the field review more effectively.

Part I goes to the type of laboratory which is being reviewed and to the nature of the procedures it performs. Much of this will be dependent upon the personnel and their qualifications. In addition, the reviewer should obtain a copy of the license and certification papers for the laboratory.

Part II requires information dealing with the volume of Medicaid billing of the particular laboratory. Such information may be helpful in ascertaining the validity of claims submitted based on its size, number of personnel, and amount of equipment. Also, State averages compared to the laboratory averages may be a further indicator of the reasonableness of the laboratory's practice.

LAB-2: LABORATORY PROFILE REPORT

Part I: Certification and Licensure Information

A. Personnel

Credentials of Laboratory Director

____ Pathologist

____ MD

____ Doctorate other than physician

____ Other Degree

____ Grandfathered

Number(s) and Qualifications of Supervisor(s)

____

____

____

____

____

Other Personnel and Qualifications

____

____

____

____

____

B. Significant Information Noted (From Review of Licensure and Certification File

C. Significant Information From Review of Correspondence or Other Files

Part II: Billing Information

1. Dollars billed ______________ and paid ______________ under Medicaid. Period in question ______________________________
2. Number of Tests Performed ______________.
3. Number of Recipients ______________.
4. Tests per Recipient ______________ compared to State Average ______________.
5. Dollars per Recipient ______________ compared to State Average ______________.

LAB-3

CLAIM SELECTION LIST

PROVIDER NAME______________________ DSHS REVIEW NUMBER____________________

PROVIDER NUMBER____________________ PREPARED BY________________ DATE________

CITY ______________________________ REVIEWED BY________________ DATE________

(1) CLAIM SELECTION NO.	(2) RECIPIENT NAME LAST FIRST	(3) DATE OF SERVICE	(4) PRESCRIBING PHYSICIAN	(5) NO RECORD FOUND (X)

TAB 4 CLAIM WORKSHEET

Recipient Name: ______________________ DSHS Review Number: ______________

Recipient Medicaid Number: ______________________ Prepared by: __________ Date: ______

Claim Selection Number: ______________________ Reviewed By: __________ Date: ______

Medicaid Claim Number: ______________________ PROVIDER NAME: ______________

Stat. Control # *Provider Claim Listing Pg. #* *Recipient Medicaid #*

				Medicaid Claim	Laboratory Record	Prescribing Physician
Date of Service/request						
Service code number						
Amt Billed	Amt Paid	Correct Billing Amt	OP / UP	Description of Service	Description of Servide	Description of Service
------------- TOTALS -----------------				Abuse Code Number	Verification (Y or N) if "N" see comments	Physician's name and phone number

Comments on Reverse:

LAB - 5
LABORATORY EQUIPMENT SURVEY REPORT FORM

Provider Name: ____________________ DSHS Review Number: ____________________

Provider Number: ____________________ Prepared By: ______________ Date: __________

City: ____________________ Reviewed By: ______________ Date: __________

Major Equip. Item	Model name and serial number	Multiple Test Capability	Use

LAB - 5 (CONT:)

LABORATORY EQUIPMENT SURVEY REPORT FORM

Major Equip. Item	Model name and serial number	Multiple Test Capability	Use

LAB-6

LABORATORY DATA COLLECTION CHECKLIST

PROVIDER NAME________________ DSHS REVIEW NUMBER________________

PROVIDER NUMBER________________ PREPARED BY________________ DATE________

City________________ REVIEWED BY________________ DATE________

	N/A	DATE WHEN COMPLETED	INITIALS	REMARKS
1. Photocopy medical records of recipients associated with selected claims (include data on type of insurance coverage and records of lab tests).				
2. Photocopy orders from physicians.				
3. Inspect laboratory for equipment capabilities. Complete LAB-5.				
4. Interview Lab Director. Complete LAB-7A.				
5. Photocopy the list of charges to physicians and others if different charge schedules are used.				

LAB - 7
LABORATORY DIRECTOR INTERVIEW GUIDE

Name and Address of Laboratory: ______________________

____

____

____

Name of Director: ______________________

Name of Interviewee: ______________________

1. What are the usual hours the director spends in the laboratory?

2. Obtain a list of the tests performed and the schedule of charges.

3. Do physicians write out all test orders, or do they telephone in test orders?

   - If telephoned in, are these calls followed by confirmation in writing?
   - If test orders are called in, does the laboratory make a notation to that effect

4. Is there written confirmation from physicians for follow-up tests conducted by laboratories? If not, explain.

5. Does the laboratory ever bill the physician for Medicaid patients, rather than directly to the Medicaid agency?

6. Does the laboratory offer individual or volume discounts for work done for physicians? If so, describe.

- Does the Medicaid agency get these same discounts?

7. What procedures does the laboratory use to identify Medicaid patients?

8. Does the laboratory ever refer lab work to other laboratories?

If so, under what circumstances?

What is the billing procedure in such cases?

9. In what category(ies) is the laboratory certified?

LAB-8

PRESCRIBER CONTACT SHEET

PAGE ____ OF ____

PROVIDER NAME ______________________ DSHS REVIEW NUMBER ______________________

PROVIDER NUMBER ______________________ PREPARED BY ______________________ DATE ____________

City ______________________ REVIEWED BY ______________________ DATE ____________

(1) CLAIM SELECTION NUMBER	(2) PHYSICIAN'S NAME AND TELEPHONE NO.	(3) RECIPIENT NAME LAST	FIRST	(4) CLAIM VERIFIED BY PRESCRIBER (Y,N)	(5) NOTES

10. Who owns the laboratory?

11. Is the laboratory part of a chain?

If so, what other labs are in the chain?

Do they all use the same charge schedules?

12. What process is followed for billing Medicaid?

LAB-9

POTENTIAL ABUSE MEASUREMENT

CLAIM SELECTION NUMBER________ DSHS REVIEW NUMBER________

PROVIDER NAME________ PREPARED BY________ DATE________

PROVIDER NUMBER________ REVIEWED BY________ DATE________

City ________ AMOUNT CLAIMED ________

LINE NUMBER	DESCRIPTION	ABUSE CODE NUMBER	UNITS	RESULT	REASON FOR RESULT AND REMARKS
I. SERVICE VERIFICATION					
1.	Does the laboratory medical record verify that a test was performed?		Y,N		
1a.	Potential abuse due to lack of any verification.	5110	$		
2.	Does the laboratory medical record verify that some lab test billed for was performed?		Y,N		
2a.	Potential abuse due to upgrading service billed for over that actually performed.	5111	$		

LINE NUMBER	DESCRIPTION	ABUSE CODE NUMBER	UNITS	RESULT	REASON FOR RESULT AND REMARKS
I.	SERVICE VERIFICATION (continued)				
3.	Does the laboratory record support that the test performed was ordered by a physician?		Y, N		
3a.	Potential abuse due to lack of physician order.	5112	$		
4.	Amount of service provided.		$		
II.	TEST PERFORMANCE				
5.	Does the laboratory have the proper certification to perform the test billed for?		Y,N		
5a.	Potential abuse due to lack of proper certification.	5120	$		
6.	Did the qualified person perform the test billed for?		Y,N,N/A		
6a.	Potential abuse due to test performance by unqualified personnel	5121	$		
7.	Does the laboratory possess equipment capable of performing test billed for?		Y,N		
7a.	Potential abuse due to lack of proper equipment.	5122	$		

LINE NUMBER	DESCRIPTION	ABUSE CODE NUMBER	UNITS	RESULT	REASON FOR RESULT AND REMARKS
III.	CHARGE PATTERN				
8.	Did the laboratory bill for single tests when multiple testing was performed?		Y,N		
8a.	Potential abuse due to single test billed when multiple test performed.	5220	$		
9.	Was the laboratory charge consistent with the usual and customary charge?		Y,N		
9a.	Potential abuse due to laboratory inflating charge above usual and customary charge?	5221	$		
10.	If a reference laboratory was used, was the charge the same as the reference laboratory charge?		Y,N		
10a.	Potential abuse due to laboratory inflating charge above reference laboratory charge.	5222	$		
11.	Did the lab bill more than once for the same service?		Y,N		
11a.	Potential abuse due to duplicate billing.	5223	$		

LINE NUMBER	DESCRIPTION	ABUSE CODE NUMBER	UNITS	RESULT	REASON FOR RESULT AND REMARKS
IV.	TOTALS				
12.	Total amount not classified as potential abuse		$		
13.	Total amount of potential abuse		$		
14.	Was any potential abuse detected?		Y,N		

LAB-10

LABORATORY REVIEW SUMMARY

PROVIDER NAME________________ DSHS REVIEW NUMBER________________

PROVIDER NUMBER________________ PREPARED BY________________ DATE________

City ________________ REVIEWED BY________________ DATE________

(1) ABUSE CODE NUMBER	(2) LAB-9 LINE NUMBER (or other source)	(3) DESCRIPTION	(4) NUMBER OF CLAIMS	(D AM
I. TOTALS OF INDIVIDUAL POTENTIAL ABUSES				
5110	1a	Potential abuse due to lack of any verification.		
5111	2a	Potential abuse due to upgrading service billed for over that actually performed.		
5112	3a	Potential abuse due to lack of physician order.		
5120	5a	Potential abuse due to lack of proper certification.		
5121	6a	Potential abuse due to test performance by unqualified personnel.		
5122	7a	Potential abuse due to lack of proper equipment.		

(1) ABUSE CODE NUMBER	(2) LAB-9 LINE NUMBER (or other source)	(3) DESCRIPTION	(4) NUMBER OF CLAIMS	(5) DOLLAR AMOUNT
I. TOTAL OF INDIVIDUAL POTENTIAL ABUSES (continued)				
5220	8a	Potential abuse due to single test billed for when multiple test performed.		
5221	9a	Potential abuse due to laboratory inflating charge above usual and customary charge.		
5222	10a	Potential abuse due to laboratory inflating charge above reference laboratory charge.		
5223	11a	Potential abuse due to duplicate billing.		
II. TOTAL OF ALL POTENTIAL ABUSES				
	13	Total number of claims indicating potential abuse.		▨
	14	Total dollar amount of potential abuse.	▨	
III. TOTAL OF UNDER-PAYMENTS				
	15	Total of claims indicating under-payments.		▨
	16	Total dollar amount of under-payments.	▨	

(1) ABUSE CODE NUMBER	(2) IAB-9 LINE NUMBER (or other source)	(3) DESCRIPTION	(4) NUMBER OF CLAIMS	(5) DOLLAR AMOUNT
IV. TOTAL OF NON-ABUSIVE CLAIMS				
	17.	Total of claims indicating no abuse.		▨
	18.	Total dollar amount of non-abusive claims.	▨	
V. TOTAL OF OVERPAYMENTS -- NON ABUSIVE				
	19.	Total non-abusive overpayments. (claims)		▨
	20.	Total dollar amount of non-abusive overpayments.	▨	
VI. TOTAL OF UNDERPAYMENTS -- NON ABUSIVE				
	21.	Total non-abusive underpayments. (claims)		▨
	22.	Total dollar amount of non-abusive underpayments.	▨	
VII. TOTALS OF SAMPLED CLAIMS				
	Sample Size	Total number of claims.		▨
	From IAB-4	Total dollar amount paid on claims.	▨	
VII. RATIOS				
	II/III	Total # of claims indicating potential abuse. # claims.		▨
		Total dollar amount of potential abuse/paid on claims.	▨	
	IV,V,VI	Total # of claims indicating no abuse.		▨
		Total dollar amount of non abuse.	▨	

MEDICAID PROVIDER REVIEW – SUMMARY REPORT

DSHS Review No. ____________

I. IDENTIFYING INFORMATION

City ____________ Region ____________

Type of Provider – Physician ☐

– Nursing home ☐

– Pharmacy ☐

- Laboratory ☐

Provider Name ____________

Provider No. ____________ Period claims paid ____________ to ____________

Review of provider cost report for year/period ended: ____________

Control Dates:

Assigned for Review ____________

Initial Desk Review Completed ____________

Field Review Completed ____________

Final Analysis Completed ____________

Supervisor's Review Completed ____________

Reviewer(s) assigned* ____________

____

Supervisor ____________

*Review staff should enter their names and initials as they will appear in the workpapers so they can be identified.

II. PROVIDER CHARACTERISTICS

A. Type of Provider

Physician	11.	General Practitioner	☐
	12.	Internist	☐
	13.	Pediatrician	☐
	14.	General Surgeon	☐
	15.	Obstetrician/Gynecologist	☐
	16.	Doctor of Osteopathy (all specialties)	☐
	19.	Other, specify ______________________	☐
Nursing Home	21.	SNF only	☐
	22.	ICF only	☐
	23.	Multiple-level	☐

B. Organization/Ownership of Provider

Physician	11.	Solo practice	☐
	12.	Group practice – unincorporated	☐
	13.	Group practice – incorporated	☐
	19.	Other ______________________	☐
Nursing Home	21.	Proprietary – sole facility	☐
	22.	Proprietary – multiple facilities, not publicly held	☐
	23.	Proprietary – multiple facilities, publicly held	☐
	24.	Not for profit – sole facility	☐
	25.	Not for profit – part of hospital	☐
	29.	Other ______________________	☐
LABORATORY	51.	Independent, no affiliation	☐
	52.	Chain outlet, publicly held	☐
	53.	Chain outlet, not publicly held	☐
	59.	Other ______________________	☐

Pharmacy

31. Chain outlet, publicly held ☐
32. Chain outlet, not publicly held ☐
33. Independent, no affiliation ☐
34. Independent, coop/voluntary affiliation ☐
39. Other ________________________________ ☐

C. Estimated Proportion of Revenues from Medicaid (Individual Physician, Facility, or Outlet)

Less than 5% ☐
5– 9% ☐
10–19% ☐
20–29% ☐
30–39% ☐
40–49% ☐
50–59% ☐
60–69% ☐
70–79% ☐
80–89% ☐
90% and over ☐

D. Total Medicaid Payments in Most Recent Calendar Quarter. $ ☐☐☐☐☐☐

E. Program Enrollment

Enrollment for____years. Date originally enrolled ____/__/____. Number of times suspended from program____.

Dates suspended _____/__/_____ _____/__/_____

Duration of suspension ___________ ___________

III. REVIEW FINDINGS

A. Disposition of Review (Check One)

1. Review completed ☐

Review not completed due to:

2. Provider cannot be located or no longer in business ☐

3. Unwilling to allow access to records ☐

4. Provider currently under review by the state agency or other investigative organizations

(explain) ____

____ ☐

5. Other (explain) ____

____

____

____ ☐

Summary Findings – Physicians

TAL NUMBER OF CLAIMS SAMPLED ____________ TOTAL DOLLARS PAID ON CLAIMS ____________

DESCRIPTION OF POTENTIAL ABUSE	ABUSE CODE NUMBER	DOLLAR AMOUNT	PERCENT OF DOLLARS PAID	NUMBER OF CLAIMS	PERCENT OF TOTAL CLAIMS
TOTALS					

IV. REVIEWER'S SUMMARY COMMENTS*

A. Conclusions Regarding Potential Abuse:

Address the following topics in these comments:

1. Potential willful misrepresentation of services
2. Possible kickbacks (as defined in Section 1909 of the Social Security Act)
3. Possible excessive referrals and lab tests (physicians only)
4. Potential abuse of patient trust funds (nursing homes only)
5. Other irregularities ______________________________

____

____

____

B. Recommendation for State Action (Give Reasons):

____

____

____

____

REVIEWER'S SIGNATURE:______________________________ Date: ______________

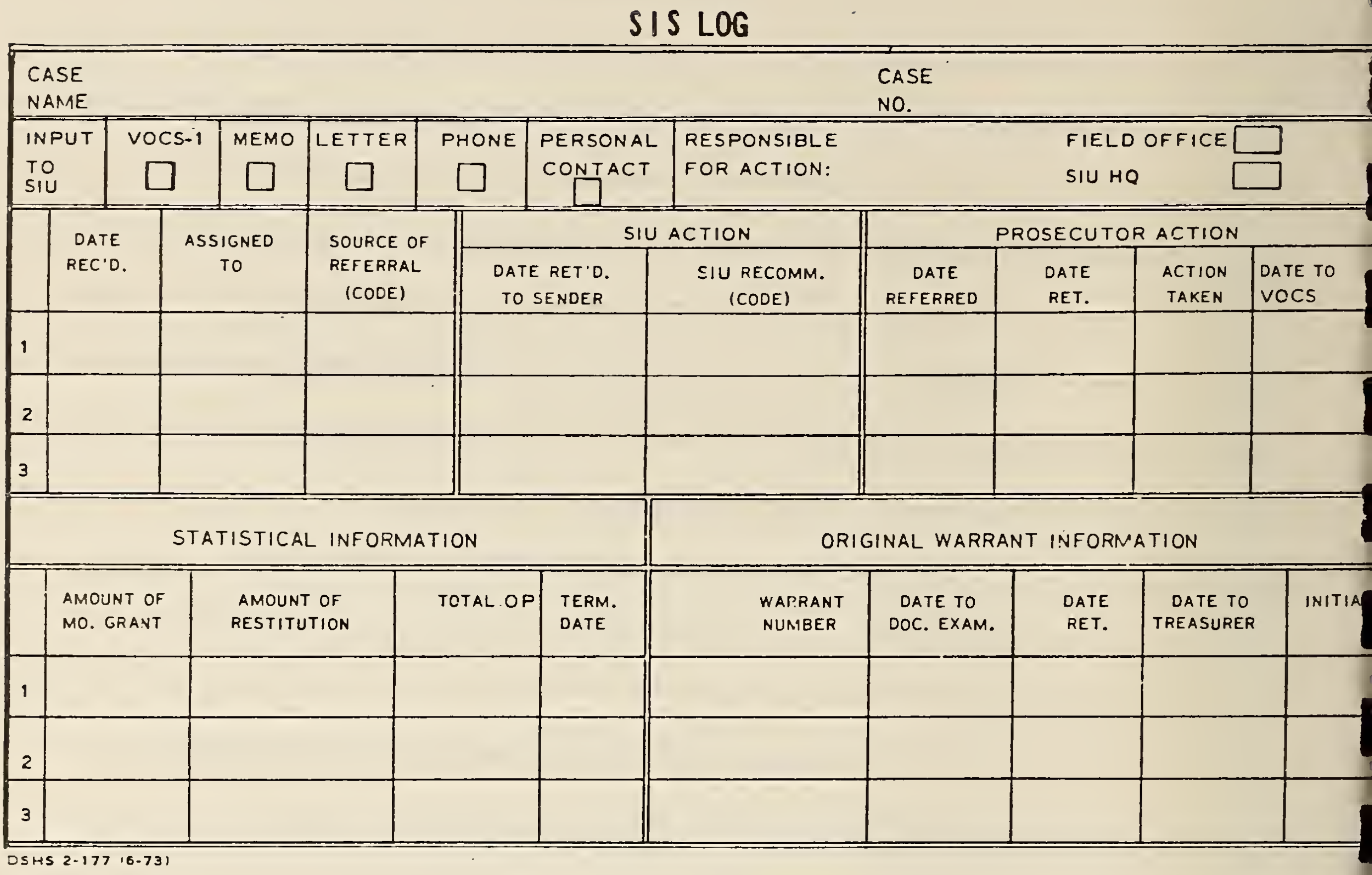
*If more space is needed, attach additional sheets.

V. SUPERVISOR'S COMMENTS*

SUPERVISOR'S SIGNATURE: ______________________________ Date: ______________

*If more space is needed, attach additional sheets.

EXHIBIT M



SIS LOG

CASE NAME						CASE NO.	
INPUT TO SIU	VOCS-1 ☐	MEMO ☐	LETTER ☐	PHONE ☐	PERSONAL CONTACT ☐	RESPONSIBLE FOR ACTION:	FIELD OFFICE ☐ SIU HQ ☐

				SIU ACTION		PROSECUTOR ACTION			
	DATE REC'D.	ASSIGNED TO	SOURCE OF REFERRAL (CODE)	DATE RET'D. TO SENDER	SIU RECOMM. (CODE)	DATE REFERRED	DATE RET.	ACTION TAKEN	DATE TO VOCS
1									
2									
3									

STATISTICAL INFORMATION					ORIGINAL WARRANT INFORMATION				
	AMOUNT OF MO. GRANT	AMOUNT OF RESTITUTION	TOTAL OP	TERM. DATE	WARRANT NUMBER	DATE TO DOC. EXAM.	DATE RET.	DATE TO TREASURER	INITIA
1									
2									
3									

DSHS 2-177 (6-73)

The Log Card is a 5x8 card. The original is kept at the Regional Office and a copy is kept at the State office.

EXHIBIT N

SPECIAL INVESTIGATIVE SECTION

OPERATING MANUAL

INDEX

Page No.

INTRODUCTION

Foreword..........

History.......... 1

S.I.S. Role in D.S.H.S.......... 2

- Objectives.......... 2
- Organizational Structure.......... 3
- The Problem - Welfare Fraud.......... 3

I. Supervisory Structure.......... 4

II. Staffing Pattern.......... 4

Organizational Chart.......... Figure I

III. Supervisory Roles.......... 4-5

IV. Case Classifications.......... 6

V. Performance Standards.......... 6

VI. Management Reports.......... 7

PROCEDURES

I. Referrals to S.I.S.......... 8

- A. General.......... 8
- B. Alleged Recipient Fraud Referrals.......... 8
- C. D.S.H.S. Employee Fraud or Financial Misconduct Referral.......... 8
  - S.I.S. Hq. Flow Chart of Incoming Complaints.......... Figure 2
  - S.I.S. Field Office Source Document Flow Chart.......... Figure 3
  - Sample of Employee Investigation.......... Figure 4

II. S.I.S. Log Card.......... 9-12

III. Prosecution Referrals.......... 12-14

- A. References.......... 12

INDEX

Page No.

B. General.. 12

C. Referral Procedures.............................. 12-14

IV. INVESTIGATIVE TECHNIQUES

A. Statement-Waiver of Rights........................ 14

B. Interviewing...................................... 14

1. General.. 14

2. Interviewing Methods............................. 15

C. Locating of Persons............................... 16-18

D. Report Writing.................................... 18-22

1. General.. 18

2. The Technique of Report Writing.................. 19

3. Protection of the Report......................... 21

4. Confidentiality of the Report.................... 22

5. D.S.H.S. Employee Misconduct Reports............. 22

E. Sources of Information............................ 22-29

1. General.. 22

2. The "Source" File................................ 22

3. Reference Sources of Information................. 23-29

a. City Directories................................ 23-24

b. Civil List...................................... 24

c. Religious Directories & Yearbooks............... 24

d. Private Sources of Information.................. 24

e. Further Sources of Information.................. 25-29

F. Knowledge & Use of Evidence....................... 29-33

1. General.. 29

2. Admissible Evidence.............................. 30

3. Admissions & Confessions......................... 30

INDEX

Page No.

4. Threats, Self-serving & Accusatory Statements..... 30

5. Acts & Statements of Conspirators................ 31

6. Expert Evidence.................................. 31

7. Documentary Evidence............................. 31

8. Character Evidence............................... 31

9. Kinds of Evidence................................ 32-33

    a. Circumstantial Evidence...................... 32

    b. Corroborative Evidence....................... 32

    c. Hearsay Evidence............................. 32

    d. Direct Evidence.............................. 32

    e. Relevant Evidence............................ 32

    f. Material Evidence............................ 32

    g. Competent Evidence........................... 32

    h. Opinion Evidence............................. 32

    i. Exhibits..................................... 32

    j. Parol Evidence............................... 33

10. Presenting Evidence in Court.................... 33

11. Chain of Evidence............................... 33

G. The "Portrait Parle"............................. 34-36

V. Personal Conduct................................. 36

VI. Telephone Credit Card Usage..................... 37

VII. Travel Expense Vouchers........................ 37-38

VIII. Equipment Control............................. 38

IX. Public Information Policy....................... 39

APPENDIX A - Legal Definitions...................... 40-46

APPENDIX B - S.I.S. File System..................... 47-53

INTRODUCTION

Adherence to established directives is an essential responsibility of all management and employees. The performance of operations in accordance with well-developed, coordinated and established directives and standards is a reflection of good management.

Directives may be in many forms. Some are oral, some written, some temporary and some more lasting. This policy applies to written, more lasting forms. It applies to procedural matters where repetitive or continuous operations are required to accomplish a given set of tasks to attain given goals or objectives. It applies to procedural matters of concern to all levels of staff.

This Operations Manual outlines the action plan for developing, coordinating, revising, and implementing a formal directive system for the Special Investigative Section (S.I.S.). The objective of this system is to stimulate prescribed action for the most effective functioning of the Special Investigative Section in carrying out its mission.

The responsibility of the internal organizational units within S.I.S. is to standardize procedures where appropriate; to control the internal processes, including timely and accurate flow of information; and to use available resources most effectively.

A formal directive system will be developed and used uniformly by all management and staff.

This formal directive system will consist of a loose-leaf S.I.S. operating manual containing a history, current policies, approved organizational structures, statement of functions, authorities, responsibilities, and relationships of the major organizational elements along with current and projected goals and objectives.

This manual will initially be issued by the Director, who will also publish revisions, decisions, supersessions and new policies as they are promulgated. Each recipient of an operating manual will be responsible for keeping it current and ensuring that its provisions are known and understood by those he supervises.

Supervisors will be held accountable for ensuring strict adherence to and compliance with the provisions of established policies and procedures.

FOREWORD

Since this manual is designed to assist each investigator in the performance of his or her day to day duties, I would like to take this opportunity to remind each investigator that although giant strides have been made in recent years, in many areas, there is still opportunity for providing equal justice for the accused, regardless of his economic status. In order that the investigator can function in a role that is outside his personal prejudices, it is necessary to develop a real sense of professionalism. Only by examining the relation of your personal sentiments and feelings to your public duties can you achieve true impartiality and neutrality. This is an educational problem in its own right, and it is equal in importance to the acquisition of new information in crime detection and investigation.

Milton Burdman

Milton Burdman
Deputy Secretary
Department of Social &
Health Services

HISTORY

The history of welfare fraud investigation in any formalized concept begins with the first fraud unit established in 1948 at the then King County Welfare Office under the control and supervision of Leonard Hegland, County Welfare Administrator.

Fraud was handled by the county welfare offices from 1948 to 1955, when Roderick Olzendam, a former Weyerhauser official, was appointed State Director of the Department of Welfare.

Olzendam established the first State Investigative Unit and the first supervisor was Louis Graves. Twenty investigators were hired and placed statewide.

During the period from 1955 to 1959 a series of events occurred which made the State Investigative Unit suspect as to abuse of its role. A County Administrator was investigated under circumstances that led to a statewide protest by County Administrators.

The result was the breaking up of the State Investigative Unit. Fraud investigation responsibilities reverted again to county offices where they remained until 1972.

In 1962 the Seattle Times published a series of articles on the Department's handling of fraud and the result was the re-creation of the State Investigative Unit, headed as lead investigator by Russ Ward. This unit of seven investigators reported originally to George Brown and in 1967 transferred into the Support Enforcement Unit under Robert Querry.

In August, 1971, S.I.S. was separated from Support Enforcement and its primary responsibilities were to train local office investigators and to investigate the more complex welfare fraud cases. Robert Neilson was appointed supervisor of the unit.

In February, 1973, two legislative bills were introduced calling for the creation of an enlarged S.I.U. and for the transferring of the responsibility of referrals to County Prosecutors from the local office administrators, to the S.I.U. The Department of Social and Health Services agreed to the legislative intent and authorized 76 man years and $1,049,647 to organize and maintain a State Investigative Unit for the 1974-75 biennium. The enlarged and reorganized S.I.U. came into being on 1 July 1973.

Robert Neilson was appointed Acting Supervisor, State Investigative Unit, and in August, 1973, the State Investigative Unit (S.I.U.) became the Special Investigative Section (S.I.S.). On November 1, 1973, Neilson was appointed as Director of S.I.S.

AN OVERVIEW OF THE SPECIAL INVESTIGATIVE SECTION'S ROLE IN D.S.H.S.

The Special Investigative Section's role in D.S.H.S. has never previously been defined. Our present mandate is a seemingly all inclusive mandate set forth in the D.S.H.S. Budget Bill for the 1974-1975 biennium. That mandate is as follows: "That within the employment level provided in Section 3 of this Act, not to exceed $1,049,647 of this amount shall be utilized exclusively for the purpose of providing a total of seventy-six man years and related costs for the State Investigative Unit whose responsibility shall be to investigate all complaints of fraud and to institute the proper corrective action."

Based on this mandate and from written as well as oral directives from the Office of the Secretary/Deputy Secretary, there was an obvious need to translate these general guidelines into a viable program of detecting, investigating, and preventing fraud with the Department.

While it is true that our major thrust will be directed towards welfare fraud prevention, detection and investigation, we cannot overlook our responsibility in the area of employee fraud.

OBJECTIVES

The major objectives of the Special Investigative Section are:

1. To investigate all referrals of probable fraud from the community, local office VOCS units or other appropriate source.

2. To institute or recommend proper corrective action as needed.

3. To coordinate all welfare fraud prosecutions for the Department of Social & Health Services with the appropriate county prosecutors or trial deputies.

4. To provide statistical reports of all fraud activities which are meaningful to both the Office of the Secretary/Deputy Secretary and the Legislative Budget Committee.

5. To develop programs for the detection and prevention of fraud.

6. To investigate all proper referrals of D.S.H.S. employee fraud or misconduct and provide investigative reports to appropriate authorities.

THE PROBLEM - WELFARE FRAUD

Welfare fraud is but one of many problems that the Department faces in a continuing effort to insure the integrity of the state's assistance programs.

Essentially, welfare fraud can be placed into three categories: Recipient Fraud, Internal Fraud (financial misconduct committed by departmental employees) and External Fraud (thefts and forgeries committed by persons outside the welfare system). Medical vendor fraud although part of the broad external fraud category, is a highly technical investigative area and is the subject of a separate section of this manual. Recipien fraud is indicated where there appears to be a deliverate attempt to conceal or misrepresent pertinent information which could affect eligibility or grant amounts. The most prevalent violations are:

Failing to report all income.

Failing to report all personal property.

Failing to report all real property.

Making other false statements material to eligibility.

Receiving financial payments for a person or persons not in the home.

Failure to report a change in status which eliminates the deprivation (Such as failing to report the return of an absent father.)

Receiving financial assistance from more than one country or from more than one state.

Receiving financial assistance for non-existant children.

Receiving multiple grants under different names.

Receiving grants directed to persons deceased (due to failure of those responsible to notify the Department that recipients are dead.)

False verifications of housekeeping expenses and child care expenses.

Misappropriation of boarding institution payments.

Misuse of food stamps and obtaining food stamps fraudulently.

Misuse of public assistance funds.

ORGANIZATIONAL STRUCTURE

General:

The organizational structure of OSI was designed for maximum operational efficiency, within the limits imposed by the man year ceiling of 76 man years (38 positions) for the present biennium.

This called for a complete restructuring into a statewide operation capable of both program development and field operations.

As a result of our own reorganization and the reorganization of other divisions within the Department of Social & Health Services, refinement and modifications of our new structure were not complete until January 1, 1974.

I. SUPERVISORY STRUCTURE

A. In order to deal effectively with program planning, development and management as well as field operations, the supervisory structure as shown on the organizational chart (see Figure I) was implemented on 1 January 1974. The supervisory structure was modified slightly from the original structure so that we could align ourselves with the modified regional structure of the Department.

II. STAFFING PATTERN

A. Investigative Staff

Our staffing pattern was based almost entirely on the statewide AFDC caseload, utilizing as a starting point, a minimal need of 1 investigator for every 2,000 active AFDC cases.

Selection of the AFDC caseload as a basis for our staffing pattern was primarily a result of the knowledge that at least 80% of the known recipient fraud in the state of Washington was AFDC connected.

The selection of this method for establishing our staffing pattern was given added significance when the Social Security Administration assumed responsibility for the previously state-administered OAA, DA, and Aid to the Blind programs effective 1-1-74. This will probably result in at least 90% of our fraud cases coming from the AFDC caseload.

B. Clerical Support Staff

The need for clerical support staff was based on the need for adequate clerical support for each regional field office, adequate clerical support for the state office headquarters, and a statistical reports compiler to develop and maintain needed fraud statistics for internal reports as well as a required annual statistical report to HEW.

III. SUPERVISORY ROLES

A. The Director of S.I.S. reports to the Deputy Director of Social & Health Services and has the following primary responsibilities:

> Planning, developing and directing a statewide program for the prevention, detection, investigation, and recommending corrective action in all state, interstate, and international welfare fraud matters, including vendor irregularities.

B. The Assistant Director reports to the Director and has the following primary responsibilities:

> Assists the Director, Special Investigative Section, in developing plans and procedures to direct the activities of the Special Investigative Section.

SPECIAL INVESTIGATIVE SECTION

1/15/74

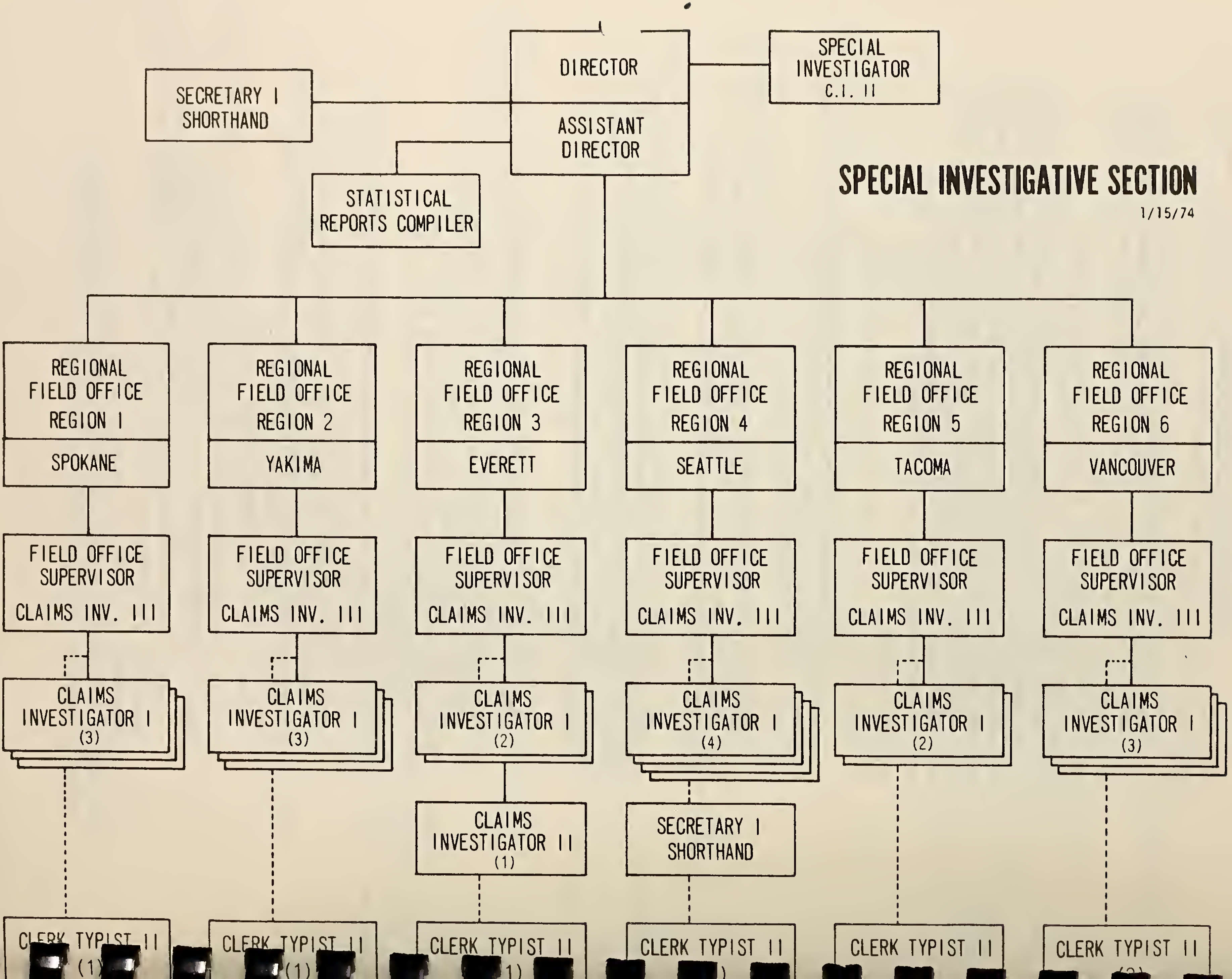

DIRECTOR
ASSISTANT DIRECTOR
SPECIAL INVESTIGATOR C.I. II
SECRETARY I SHORTHAND
STATISTICAL REPORTS COMPILER
REGIONAL FIELD OFFICE REGION I
SPOKANE
REGIONAL FIELD OFFICE REGION 2
YAKIMA
REGIONAL FIELD OFFICE REGION 3
EVERETT
REGIONAL FIELD OFFICE REGION 4
SEATTLE
REGIONAL FIELD OFFICE REGION 5
TACOMA
REGIONAL FIELD OFFICE REGION 6
VANCOUVER
FIELD OFFICE SUPERVISOR CLAIMS INV. III
CLAIMS INVESTIGATOR I (3)
CLAIMS INVESTIGATOR I (3)
CLAIMS INVESTIGATOR I (2)
CLAIMS INVESTIGATOR I (4)
CLAIMS INVESTIGATOR I (2)
CLAIMS INVESTIGATOR I (3)
CLAIMS INVESTIGATOR II (1)
SECRETARY I SHORTHAND
CLERK TYPIST II (1)
CLERK TYPIST II (1)
CLERK TYPIST II
CLERK TYPIST II
CLERK TYPIST II
CLERK TYPIST II

Figure 41

Participates in development of plans, policies, and procedures to assure the uniformity of operations, reports, and conformance to acceptable standards; performs the duties of the Director, Special Investigative Section during his absence;

Reviews reports for accuracy and effectiveness; conducts meetings and conferences with staff to evaluate and improve effectiveness of field operations.

Provides first line supervision for the Regional Field Office Supervisors and the administrative and clerical staff assigned to the headquarters of the Special Investigative Section;

Develops and implements training programs and participates in budget preparation and administration;

Coordinates activities of regional field offices with other divisions, state offices and federal agencies.

C. Regional Field Office Supervisors report to the Assistant Director and have the following primary responsibilities:

Directs, through assigned Claims Investigators and clerical staff the operations of a field office of the Special Investigative Section. Responsible for direct supervision of all welfare fraud complaints referred to the field office for investigation and/or referral to the proper county prosecutor for possible criminal action. Plan, coordinate, assign and supervise the activities of all assigned personnel.

Develop and conduct training for the field office investigative staff in all areas of investigative technique, development and preservation of physical evidence, effective investigative report writing, conduct as a witness when required to appear in court on behalf of the State in criminal fraud cases.

Screen all incoming fraud complaint referrals and make a determination that fraud is or is not apparent. If fraud is apparent, assign to an investigator. If fraud is not apparent, return the referral with recommendation as to disposition.

Review all completed investigative reports to insure completeness and compliance with standard operating procedures. Make changes as required. Make final decision in each completed case whether to refer to county prosecutor for possible criminal action or return case to the local office administrator for disposition.

Personally conduct investigations of complicated and complex cases assigned to him by the Director or Assistant Director.

Develop and plan changes to Regional Field Office standard operating procedures designed to improve the efficiency and effectiveness of the field office.

Appear in District and Superior Court as a witness when required.

Conferences with superiors and subordinates to clarify matters of departmental policies, rules and regulations.

IV. CASE CLASSIFICATION

A well-defined case classification system is a necessary and extremely useful management tool.

The proper identification and classification of all referrals to S.I.S. has a direct bearing on case assignments, production control, quality control, performance standards and personnel classification.

Based on the past six months operating experience of S.I.S. and input from some of the larger VOCS units, it was determined that all referrals to S.I.S. would be classified as follows:

1. Unreported income or assets;
2. Unreported change in family composition;
3. Duplicate assistance;
4. Lost or stolen warrants;
5. Misstatement, omission or misrepresentation of material facts;
6. Out of state referrals;
7. Food stamp irregularities;
8. Personnel investigations;
9. Vendor irregularities;
10. Others.

V. PERFORMANCE STANDARDS

A. General: Recognizing that performance standards must be set if we are to have the means of evaluating individual job performances justifying future changes in our staffing pattern, and to give each employee a tangible guide toward self improvement, the following standards have been set:

B. Investigative Staff: A system of evaluating investigative staff cannot be based on just the number of referrals completed or the number of referrals accepted for prosecution.

For this reason, a statistical study was made utilizing S.I.S. production figures. These figures indicate the average number of cases completed by each investigator was 20. The average number of cases referred for prosecution per investigator was 5. These production norms in combination with personal observation and experience, quality of the investigations completed, and individual initiative, will be utilized to rate overall job performance.

In setting these performance standards, it is recognized that they do not represent superior or maximum performance but they do represent an average satisfactory performance. We believe these standards are reasonable and provide the supervisor and the investigator a necessary guide for evaluation and training. In addition, it is hoped that by developing more efficient investigative techniques and office procedures, that these performance standards can be upgraded in the near future.

C. Clerical Staff: Performance standards for the clerical staff cannot be tied into a production figure, therefore, must be based entirely on the following criteria:

1. Personal observation;
2. Completion of assigned tasks (quantity);
3. Quality of completed work;
4. Initiative.

VI. MANAGEMENT REPORTS:

The Special Investigative Section provides monthly fraud statistical reports to the Office of the Secretary/Deputy Secretary, D.S.H.S. These fraud statistics are distributed by S.I.S. as directed by the Deputy Secretary.

The S.I.S. statistical reporting system has the capability of providing complete and accurate statistical information relating to every facet of welfare fraud.

Monthly fraud statistical summaries and special one-time statistical analysis are provided field office supervisors for their use as management tools.

I. REFERRALS TO S.I.S.

A. General:

A referral is normally a request to S.I.S. by an individual or organization requesting an investigation be initiated, to determine if a fraudulent or other illegal act has been committed.

Referrals are received primarily from local office VOCS units in the case of alleged recipient fraud and from the Office of the Secretary/Deputy Secretary in the case of D.S.H.S. employee fraud or misconduct.

B. Alleged Recipient Fraud Referrals:

As stated above, these referrals will originate with local office VOCS units and will be received in S.I.S. on an S.I.S. referral form, known as a "VOCS-7".

The VOCS-7 is a one-page, four-copy carbon turnaround form and is utilized by VOCS to refer cases of probable fraud to S.I.S.

The first section of the VOCS-7 is completed by VOCS worker and all four copies, along with copies of other pertinent documents (complaint form, recipient application, profile, etc.), are sent to the appropriate S.I.S. Regional Field Office.

Note: S.I.S. personnel are reminded that local office VOCS workers are required to observe guidelines set forth in the VOCS procedural manual when completing a VOCS-7 fraud referral. Therefore, S.I.S. investigative personnel must be thoroughly familiar with the S.I.S. referral instructions on page 45 of the VOCS procedural manual.

The bottom half of the VOCS-7 is used by the S.I.S. investigator to report to VOCS, on the progress of a referral and to report specific actions taken or recommended to be taken, upon completion of the investigatory process.

Flow charts showing step by step movement of typical VOCS-7's through S.I.S. are shown in Figures 2 and 3.

C. D.S.H.S. Employee Fraud or Financial Misconduct Referral:

All referrals of alleged fraud or financial misconduct on the part of D.S.H.S. employees, are received in S.I.S. State Office Headquarters.

These cases are assigned for investigation by the Director or Assistant Director. Employee cases received from any other source will be forwarded to S.I.S. State Office Headquarters in Olympia, utilizing a sealed envelope marked "Confidential".

A departmental policy memo dealing with employee fraud and/or financial misconduct will be published in the near future.

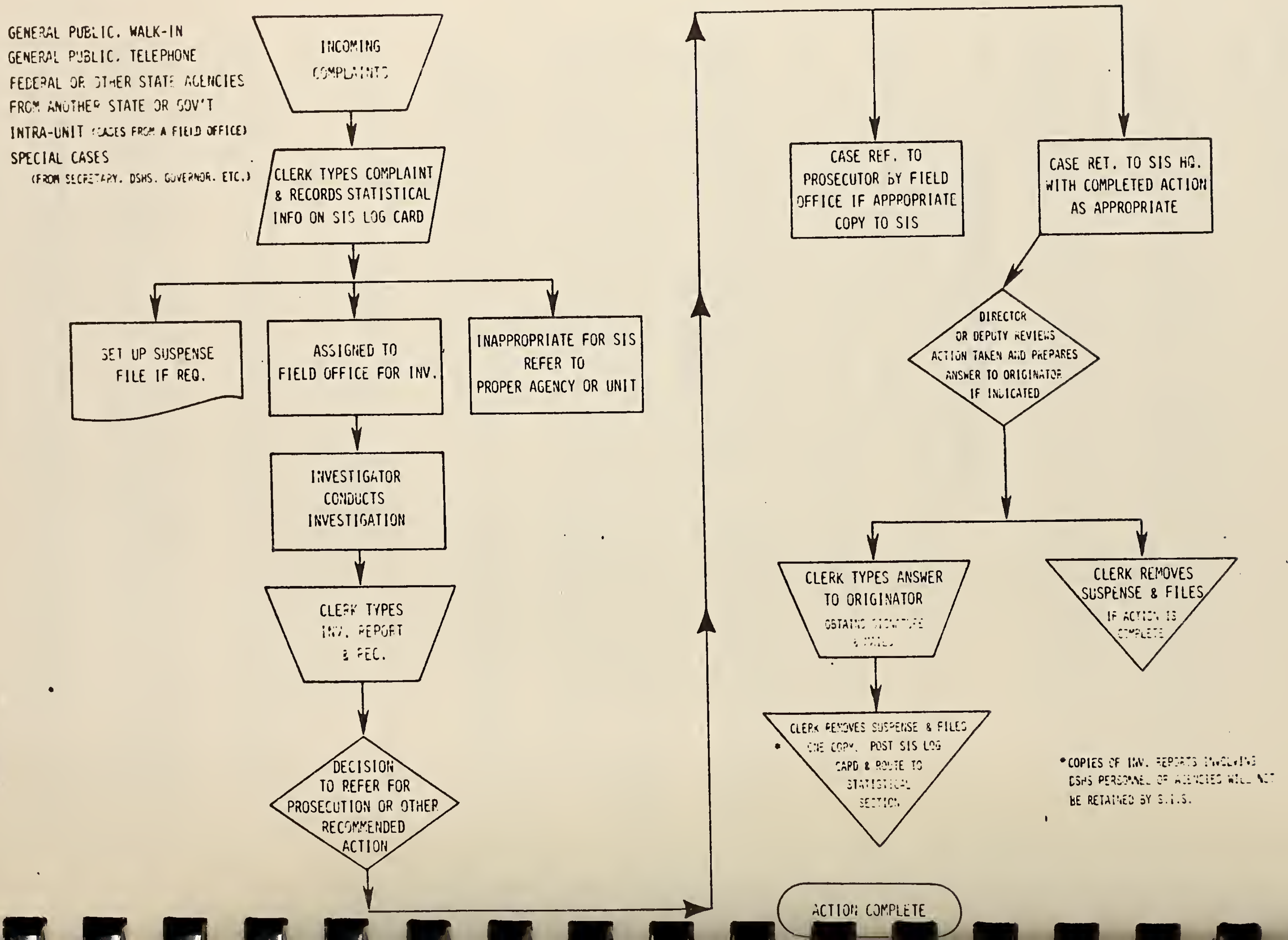
This manual will be re-written at that time to conform with that policy memo.

SPECIAL INVESTIGATIVE SECTION

PROCEDURES

Special Investigative Section Headquarters, Olympia

FLOW OF INCOMING COMPLAINTS


GENERAL PUBLIC. WALK-IN
GENERAL PUBLIC. TELEPHONE
FEDERAL OR OTHER STATE AGENCIES
FROM ANOTHER STATE OR GOV'T
INTRA-UNIT (CASES FROM A FIELD OFFICE)
SPECIAL CASES
(FROM SECRETARY. DSHS. GOVERNOR. ETC.)
INCOMING COMPLAINTS
CLERK TYPES COMPLAINT & RECORDS STATISTICAL INFO ON SIS LOG CARD
SET UP SUSPENSE FILE IF REQ.
ASSIGNED TO FIELD OFFICE FOR INV.
INAPPROPRIATE FOR SIS REFER TO PROPER AGENCY OR UNIT
INVESTIGATOR CONDUCTS INVESTIGATION
CLERK TYPES INV. REPORT & REC.
DECISION TO REFER FOR PROSECUTION OR OTHER RECOMMENDED ACTION
CASE REF. TO PROSECUTOR BY FIELD OFFICE IF APPPROPRIATE COPY TO SIS
CASE RET. TO SIS HQ. WITH COMPLETED ACTION AS APPROPRIATE
DIRECTOR OR DEPUTY REVIEWS ACTION TAKEN AND PREPARES ANSWER TO ORIGINATOR IF INDICATED
CLERK TYPES ANSWER TO ORIGINATOR
OBTAINS SIGNATURE & MAILS
CLERK REMOVES SUSPENSE & FILES
IF ACTION IS COMPLETE
* CLERK REMOVES SUSPENSE & FILES ONE COPY. POST SIS LOG CARD & ROUTE TO STATISTICAL SECTION
ACTION COMPLETE

*COPIES OF INV. REPORTS INVOLVING DSHS PERSONNEL OF AGENCIES WILL NOT BE RETAINED BY S.I.S.

Figure #2

Special Investigative Section Field Office

SOURCE DOCUMENT FLOW CHART

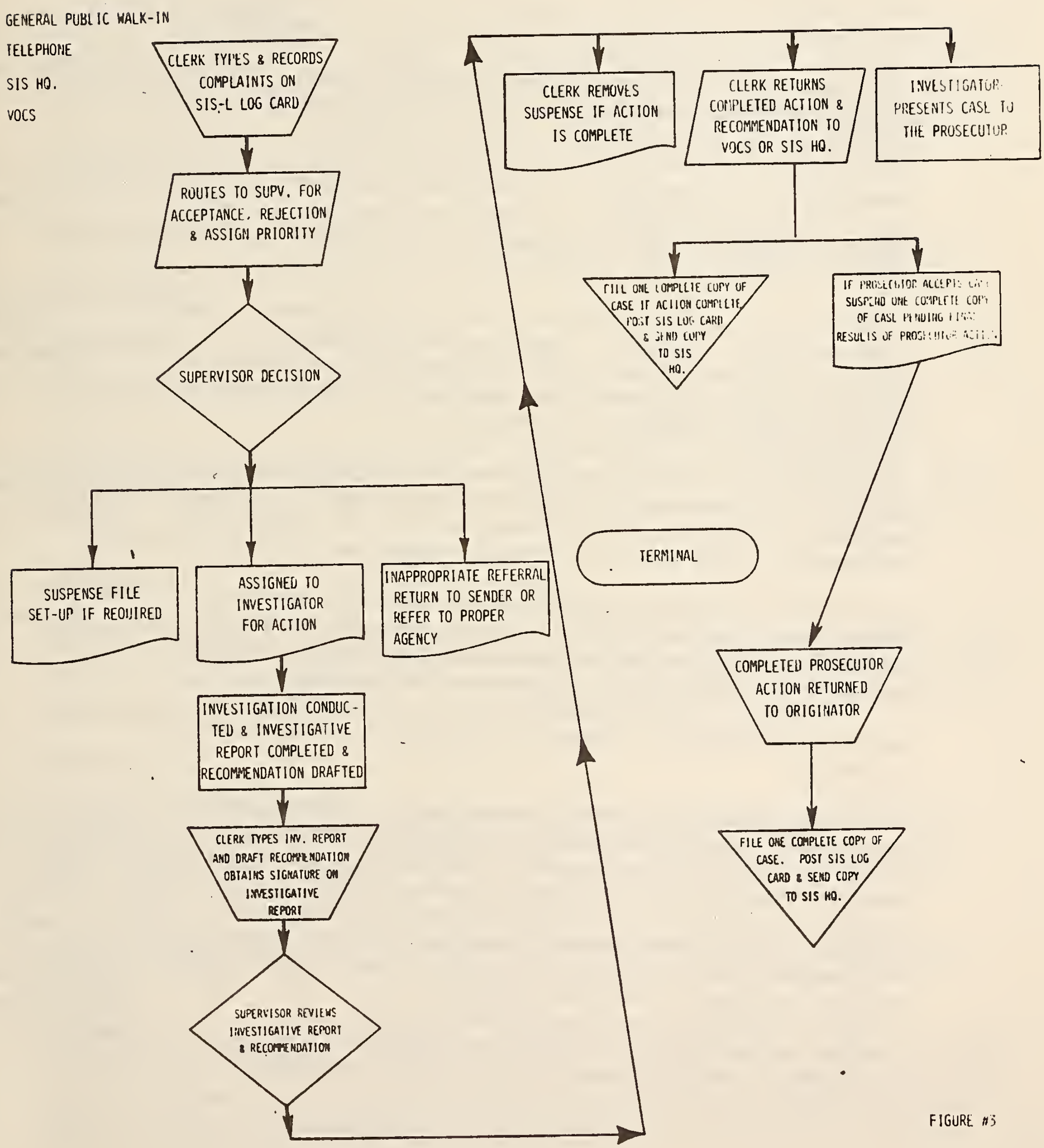

GENERAL PUBLIC WALK-IN
TELEPHONE
SIS HQ.
VOCS
CLERK TYPES & RECORDS COMPLAINTS ON SIS-L LOG CARD
ROUTES TO SUPV. FOR ACCEPTANCE, REJECTION & ASSIGN PRIORITY
SUPERVISOR DECISION
SUSPENSE FILE SET-UP IF REQUIRED
ASSIGNED TO INVESTIGATOR FOR ACTION
INAPPROPRIATE REFERRAL RETURN TO SENDER OR REFER TO PROPER AGENCY
INVESTIGATION CONDUCTED & INVESTIGATIVE REPORT COMPLETED & RECOMMENDATION DRAFTED
CLERK TYPES INV. REPORT AND DRAFT RECOMMENDATION OBTAINS SIGNATURE ON INVESTIGATIVE REPORT
SUPERVISOR REVIEWS INVESTIGATIVE REPORT & RECOMMENDATION
CLERK REMOVES SUSPENSE IF ACTION IS COMPLETE
CLERK RETURNS COMPLETED ACTION & RECOMMENDATION TO VOCS OR SIS HQ.
INVESTIGATOR PRESENTS CASE TO THE PROSECUTOR
FILE ONE COMPLETE COPY OF CASE IF ACTION COMPLETE. POST SIS LOG CARD & SEND COPY TO SIS HQ.
IF PROSECUTOR ACCEPTS CASE SUSPEND ONE COMPLETE COPY OF CASE PENDING FINAL RESULTS OF PROSECUTOR ACTION.
TERMINAL
COMPLETED PROSECUTOR ACTION RETURNED TO ORIGINATOR
FILE ONE COMPLETE COPY OF CASE. POST SIS LOG CARD & SEND COPY TO SIS HQ.

FIGURE #5

DEPARTMENT OF SOCIAL AND HEALTH SERVICES **Memorandu**

TO: Robert E. Neilson
Director
Special Investigative Section
3945-8th Ave. SE MS 36-1
Lacey WA 98503

DATE: Current Date

FROM: Your Name, Title, Office Location

SUBJECT: DOE, John F.
1314 W. 17th St.
Olympia WA 98501
EMPLOYEE INVESTIGATION

I. Paragraph I will be utilized to indicate the date of referral and the source of referral. The source of referral will always be the name of the Director, S.I.S.

II. Paragraph II will consist of a very brief statement of allegation, suspicion, etc. It is not necessary to reveal the source of allegation or any other detail. Example: "It is alleged that Mr. John Doe falsified an application for food stamps."

III. Briefly state the known facts: Dates of employment of subject of investigation - be specific. Example: "John Doe has been employed by D.S.H.S. since July 1, 1972". It is not necessary in Paragraph III to identify by job description. His job identity and period of time in his one or more jobs should be covered in the Field Investigation paragraph.

IV. Field Investigation information may be written in a chronological pattern. Any enclosures of statements, documents, etc. will be cited in the chronological sequence. Example: "Interviewed employee on July 6, 1972". (See Enclosure I, Statement of John Doe). He denies allegation in this statement.

All enclosures shall be numbered and labelled consecutively and will follow the chronological narrative. Be sure to identify by title or role any and all persons referred to in the investigation report. Example: "On July 2, contact was made with Jane Smith, Supervisor of subject."

Refer to employee as "subject" after using his name and title in the opening sentence.

After reporting under Field Investigation section, and following the attached documents, you may label a page, separate from the report itself, "Personal observations of Investigator". This supplement to the report itself is not necessary but may be used to share your opinion to the reader of the entire report. It may also be used to record information not relative to the current investigative report itself. Example: In the course of the investigation, I was advised that subject was investigated by the Big City Police Department involving forgery in May, 1971. He was convicted and placed on probation by Superior Court, etc. Note: If the subject was investigated and found not guilty or had case dismissed, it should not be included in your "Personal observation" supplement.

FIGURE 4

MEDICAL VENDOR FRAUD

GENERAL:

Combating fraud in the medical assistance program (Title XIX) requires specific coordination and investigative techniques not generally required in the investigation of public assistance recipient fraud. The Office of Special Investigation, as the designated office within the Department of Social and Health Services, to investigate "all complaints of fraud and to institute the proper corrective action", we, of course, have the responsibility for investigating all reported cases of fraud in the Medical Assistance Program Title (XIX).

In order to align ourselves with federal regulations governing fraud in the medical assistance program the following broad guidelines are to be implemented.

REFERRALS:

In addition to receiving referrals in the same manner as all other fraud referrals, the Office of Special Investigation will maintain a close liaison with the nursing home audit section and cost reimbursement section of the Department. We will not only accept referrals from these sections but will review all reports of nursing home audits for possible criminal violations.

REPORTS:

As the designated investigative agency within the Department to investigate all cases of welfare fraud including Title XIX medical vendor fraud, OSI also has the responsibility for compiling all fraud statistics and fraud related reports required by state or federal regulations.

COORDINATION:

In order to protect the vital interests of both the Department and the users of the numerous medical programs administered by the Department, it is of paramount importance that close coordination between OSI and all affected sections within the Department be maintained.

As a guideline for OSI staff members, the following people within DSHS are most often affected by an investigation involving medical vendor fraud:

Nursing Home Affairs, Ed Burke, 3-5586; Audit Section, Ray Carter, 3-2720; Central Disbursements, Bob Caetano, 3-7155; Health Services, Jim Blakeley, 3-1768; Pharmaceutical Consultant, Bill Pace, 3-7313. Coordination with Region X Social and Rehabilitation Services will be done at the state office level by the assistant director.

DUE PROCESS OF LAW:

OSI's methods of investigation in medical vendor fraud will not differ substantially from those methods used in other types of fraud investigations as set forth in preceding chapters of this investigative manual. Staff members are specifically reminded that in all situations in which there is a question of fraud, care will be taken to insure that an individuals legal rights are not infringed upon and that the principals right of due process of law are observed at all times.

Federal Regulations (45 CFR 250.80 (27)(47)) require that states maintain the secrecy (identity) of medical vendor providers who are involved in cases referred to a prosecutor for possible criminal charges. A numbering system has been set up in our state office headquarters that complies with the federal regulations.

DEFINITION OF FRAUD:

Federal regulations (45 C 250.80 (1)) states that "the definition of fraud for purposes of this section will be determined in accordance with state law. Although fraud may be defined in many ways the state statute used most often in prosecuting cases of medical vendor fraud is the larceny statute RCW 9.54.010, which reads as follows:

> LARCENY. Every person who, with intent to deprive or defraud the owner thereof --
>
> (1) Shall take, lead or drive away the property of another; or
>
> (2) Shall obtain from the owner or another the possession of or title to any property, real or personal, by color or aid of any order for the payment or delivery of property or money or any check or draft, knowing that the maker or drawer of such order, check or draft was not authorized or entitled to make or draw the same, or by color or aid of any fraudulent or false representation, personation or pretense or by any false token or writing or by any trick, device, bunco game or fortune-telling; or
>
> (3) Having any property in his possession, custody or control, as bailee, factor, pledgee, servant, attorney, agent, employee, trustee, executor, administrator, guardian or officer of any person, estate, association or corporation, or as a public officer, or a person authorized by agreement or by competent authority to take or hold such possession, custody or control, or as a finder thereof, shall secrete, withhold or appropriate the same to his own use or to the use of any person other than the true owner or person entitled thereto; or
>
> (4) Having received any property by reason of a mistake, shall with knowledge of such mistake secrete, withhold or appropriate the same to his own use or to the use of any person other than the true owner or person entitled thereto; and

(5) Every person who, knowing the same to have been so appropriated, shall bring into this state, or buy, sell, receive or aid in concealing or withholding any property wrongfully appropriated, whether within or outside of this state, in such manner as to constitute larceny under the provisions of this chapter -- Steals such property and shall be guilty of larceny.

JURISDICTION:

Since most medical vendor fraud cases entail violations of both federal and state criminal statutes, dual jurisdiction occurs in most cases. It is the Department's policy to refer cases of this type to a county prosecutor first. If the county prosecutor declines to file charges it is the responsibility of the OSI field office supervisor to make a determination as to whether the case has sufficient merit to warrant being referred to a U. S. attorney for possible prosecution under federal statutes.

RESTITUTION:

Cases of medical vendor fraud that do not result in criminal charges being filed, and where there is a sum of money owed to the state will be referred to the Office of Central Disbursements for necessary action.

should become thoroughly familiar with these policy guidelines.

D. Special Referrals:

The Secretary or Deputy Secretary of D.S.H.S. may, on occasion, request that S.I.S. conduct an investigation of a type not covered in the preceding paragraphs. When this does occur, the Director or Assistant Director will issue special instructions at the time the case is assigned for investigation.

II. S.I.S. LOG CARD (D.S.H.S. Form No. 2-177)

An S.I.S. Log Card is initiated for each case referred to the Special Investigative Section. This will provide for an alphabetical control of those cases which are active or pending in S.I.S.

All statistical data is gathered from these Log Cards. The cards will be used in preparing a monthly S.I.S. activity summary.

A copy of all S.I.S. Log Cards will be forwarded from each field office to S.I.S. headquarters at the time of initiation.

A copy of completed cards are sent to S.I.S. headquarters monthly. The cut-off date for the completed cards is the last day of each month. The suspense date for all completed cards to be at S.I.S. headquarters is the 5th working day of each month.

These cards are also used by the Field Office Supervisors for control of back-log, investigator's caseload size, and any other appropriate supervisory control or function.

The organization of the Log Cards in a 5 x 8 card box is based on the status of each referral. The card box would therefore have four sections, as indicated below:

1. Active - S.I.S. Log Card Pending Assignment:

   This section contains all cards for referrals received but not assigned to an investigator.

2. Active - S.I.S. Log Card Pending Investigation:

   This section contains all cards for referrals that have been assigned for investigation but investigation has not been completed.

3. Active - S.I.S. Log Card Pending Prosecution Action:

   This section contains all cards for referrals that have been approved or referred for prosecutor action. A Xerox copy of these cards will be forwarded to S.I.S. Headquarters at the time they are referred for prosecution.

II. S.I.S. LOG CARD - Continued

4. Completed - Case Closed:

This section contains all cards for referrals that have been completed. These cards will be held and forwarded to S.I.S. Headquarters in Olympia once a month.

Entry Instructions:

Case Name: Last name, First name, Middle name;

Case Number: LO Number, Program Code Letter, and Basic. Also, enter MA if medical assistance case;

Input to S.I.S: Place an "X" in the box that indicates how the referral was received in S.I.S;

Responsible for Action: Place an "X" in the box indicating who has responsibility for completing action;

(Responsibility will normally be assigned by the office receiving this referral)

Date Received: Date referral received and logged in at the area field office or S.I.S. Headquarters;

Assigned to: S.I.S. Investigator to whom case is assigned;

Source of Referral: Enter code number of source of referral. Code numbers as follows:

1. VOCS
2. Community
3. State agencies (Secretary, D.S.H.S., Governor, Treasurer, etc.)
4. Others (law enforcement agencies, out of state, etc.)

S.I.S. Action: 1. Date referral is returned to sender with the appropriate S.I.S. recommendation. When the source of referral code is 2 or 3, the date entered will be the date the case is returned to the local office VOCS unit, or the date a report of action is transmitted to the referring agency if required (i.e., no report of action taken is required when the source of referral code is 2 (community).

S.I.S. Recommendation:

II. S.I.S. LOG CARD - Continued

2. Enter code number of the S.I.S. recommendation. Code numbers are as follows:

   01 Allegation disproved - No further action necessary.

   02 Probable fraud - Intent cannot be proven. Recommend civil or administrative action to effect restitution.

   03 Fraud - Will be referred to the appropriate county prosecutor.

   04 Fraud - Agency error involved which negates our ability to refer for prosecution.

   05 Other - Brief explanation on reverse side.

Prosecutor Action:

1. Date referred is the actual date case is referred for prosecution.

2. Date returned is the date case is received back in the field office from a prosecutor. Action taken will be coded as follows:

   1. When a referral to the prosecutor has had an action taken by the prosecutor enter "yes" & explain the action on the reverse side of the S.I.S. Log Card. The explanation will includ the results of any plea bargaining and/or judicial action.

   2. When a referral to the prosecutor is returned without action, enter "no" and explain the reason the case was returned without action on the reverse side of the S.I.S. Log Cards.

Date to VOCS: Enter the date that the results of prosecutor action was forwarded to the appropriate VOCS unit.

Statistical Information:

1. Enter the amount of the monthly grant at the time the case was referred to S.I.S. If the case was terminated prior to referral to S.I.S., enter the amount of the monthly gran at termination.

2. Enter the amount of restitution ordered by court action.

3. Enter the total amount of current overpayment including the 25% penalty. Do not include prior overpayments that have no direct bearing on the present referral.

II. S.I.S. LOG CARD - Continued

4. Enter the date the grant was terminated as a direct result of the current referral. If the case had been terminated previously as a result of circumstances not related to the present referral, a suffix "A" will be entered immediately following the termination date.

Special Documentation Required:

1. Enter the warrant(s) number(s) of any original warrants referred to the Document Examiner.

2. Enter the date that the original warrant(s) were transmitted to the Documents Examiner.

3. Enter the date that the original warrant(s) were received back from the Document Examiner.

4. Enter the date that original warrant(s) were returned to the Treasurers Office. If the original warrants were returned to the S.I.S. Headquarters for hand-carrying to the Treasurers Office, enter the date the warrant(s) were transmitted to S.I.S. Hq.

5. Enter the initials of the person who actually returned the warrant(s) to the Treasurers Office or transmitted them to S.I.S. Hq.

III. PROSECUTION REFERRALS

A. References: WAC 388-44-020 (Fraud-defined)

WAC 388-46-010 (Fraud-criminal prosecution)

B. General:

The above-cited references are the backbone of this organization. Every decision we as investigators or supervisors make regarding a determination of welfare fraud, must find its authority in one or both of these regulations. This means that whether you refer a case for criminal prosecution or return it to the local office administrator, the authority for your decision must be found in these regulations.

C. Referral Procedures:

(1) Every referral to a county prosecutor must be read and initialed by the Regional Field Office Supervisor.

(2) All referrals to a county prosecutor will be hand-carried, and not mailed.

(3) In order to maintain valid statistics, Field Office Supervisors will consider a case as referred for prosecution at the time the case is delivered to the prosecutor and not when the case is accepted for prosecution. If a case is rejected by the Prosecutor, it will still count as a case referred and any subsequent action by the field office would be reflected in other statistics.

As an example: On 10-1-73, an investigator hand-carries a case to the prosecutor. The prosecutor decides against accepting the case and recommends civil or administrative action. The case would be counted as a referral and if the case was returned to the L.O.A. with a specific recommendation, it would be counted as a case closed.

(4) In preparing cases for prosecution, investigative personnel are reminded that: When two or more persons are involved in an alleged fraud but only one personally committed the act or acts, your investigation and/or referral should include anyone suspected of aiding, abetting, assisting or counseling the other in the commission of the act.

(5) An extremely important part of our job as an investigative agency is a continuing ability to provide each deputy prosecutor or trial deputy not only well-prepared, well-documented cases, but to provide them with any assistance they might need to expedite our cases through the criminal justice system.

(6) Each field office supervisor has the responsibility to insure that every investigator is fully aware of the professional attitude expected of them in any court proceedings. A lack of professional attitude could be reflected in many ways; some of the most important do's and don'ts are:

a. Before the day of trial, take whatever steps are necessary to insure your knowledge of your case is as complete as you can possibly make it.

b. While testifying, be impartial, not antagonistic, to either the prosecutor or defense attorney. Avoid giving answers that are impertinent or sarcastic. Answer questions asked by prosecutor or defense attorney as briefly as possible. Do not go into long explanations or dissertations of either the case or the law pertaining to the case.

c. If a defense attorney attacks you or the entire welfare system, do not be trapped into attempting a defense of either the system or yourself. The prosecutor will defend you and the system is not on trial.

d. Speak in a clear voice, loud enough to be heard by the Judge, court reporter and all members of the jury.

Address the jury rather than the Judge.

(7) Investigators will be responsible for following and reporting the status of all cases they have referred for prosecution. This includes the time a case is accepted by the prosecutor until final disposition of the case has been made by the courts or the prosecutor's office. Make certain that local office VOCS units receive timely information and/or copies of court orders.

IV. INVESTIGATIVE TECHNIQUES

A. Statement of Rights-Waiver of Rights:

The normal and prescribed procedure in interviewing any recipient regarding a charge of possible fraud, or in interviewing an employee in a case involving possible job-oriented financial misconduct, or in interviewing any person relative to a case under investigation, (referred hereafter as subject) the investigator shall first identify himself thoroughly. The investigator will explain to the subject that there has been an allegation made and explain the allegation.

Prior to discussing the matter any further, the investigator is required to read and explain the Constitutional rights and is required to obtain a waiver of those rights.

It is recommended that the subject be asked to read the rights, while those rights are being read aloud by the investigator. Having had those rights read and explained, the subject is asked to place his signature on the line indicated. Subject is then asked if he desires to sign a statement known as the Waiver of Rights statement, which indicates he understands these rights and agrees to a discussion of the matter without the benefit of an attorney being present. He shall be asked if he understands that anything he says may be used against him in a court of law.

The subject is told that even though he signs this statement, he has the right to exercise his Constitutional rights at any time during the interview. If the subject refuses to sign the explanation, or refuses to sign the Waiver of Rights, and/or indicates his desire to have a lawyer present, the interview is terminated. The subject may decline to sign the explanation and the waiver, but still has the right to voluntarily continue the interview.

Each investigator shall sign the document as witness in the space provided. Also, the investigator should date their witnessing signature with the time of signing included.

B. Interviewing:

(1) General - Interviewing is an art which must be learned and

then practiced, so as to focus on essentials and obtain the truth. The interviewee must be motivated to cooperate. This means the investigator must quickly recognize the nature and personality of the interviewee, and frame his strategy accordingly. Try to win confidence early. Recognize areas of personal interest and expand on them. Gain his confidence. You should give the impression of being frank, sincere and objective.

(2) Interview Methods -

(a) When interviewing, the subject tells his version of the facts and/or describes his association with the subject of the investigation. This is done first without interruption by questions or suggestion. Hear the complete version from the subject before you take out your notebook. To start an interview with a notebook in hand is inviting a deep-freeze atmosphere. After you have the story once, you can go back and review with your question and answer interview and then make your notes.

Make a good, readable, understandable account in your notes so that you won't have trouble making an accurate report of your interview in your report. Only if the subject gets off the subject or starts going far afield does the investigator interrupt to guide the narrator back to the subject. When the narrator has told his version or when it is seen that he can't stick with the subject, start the question and answer interview going back to where the narrator's story began, following his mental notes, frame and fill in the details. When asking questions, phrase them so they will be easily understood.

(b) Avoid leading questions. Avoid questions such as "Isn't it true?" A leading question assumes a fact. If the subject wishes to please the investigator, he will simply accede to the suggestion implied in the question.

(c) Your job is to gather facts, not give opinions. If the person interviewed starts going far afield, he should be guided back to the subject courteously but firmly. The subject should be permitted to qualify his statements and amplify on his explanation. This should be followed by questions requiring a yes or no answer in order to be sure his statement or explanation is understood. At the close of the interview, it is important to watch for casual remarks that can be expanded on.

(d) We do not want phone-call interviews unless absolutely necessary. This type of interview is not an investigation. When it is necessary and you do interview by phone, so state in your investigation report.

(e) Witnesses should never be interviewed in a group. One witness, in telling his version of the facts, will unconsciously transmit it to another witness who overhears him. Witnesses in a group tend to compare notes and make their stories correspond. Accurate reporting of the different recollections of each witness, not uniformity of recollection, is the only way to establish the facts. A witness who is sullen and uncooperative in the presence of his family, work or business associates may prove surprisingly willing and helpful when interviewed in private.

(f) Give a great deal of thought to your technique. Can you improve on it? Formulate in your mind the general line of questions you are going to ask before you make your call. As the interview is being conducted, keep in mind the possibility that some answers may open up an entirely new line of inquiry. Always follow up by asking the additional questions and conducting whatever additional investigation is necessary. After your interview, think back on it. What could you have done to improve on it? Remember these points and you will constantly gain in proficiency.

C. Locating of Persons:

(1) An investigator sooner or later must reach a decision as to how much effort he should expend in trying to locate a witness. This decision, of course, depends upon the information the missing witness is expected to know and how this will affect the particular assignment. It should go without saying that all effort should be made in locating any individual that has personal knowledge that could influence the decision of a particular case.

(2) The location of persons is mostly a matter of common sense and imagination. It is not in any way mysterious and is a fundamental skill of a trained and experienced investigator. There are many and varied tools that can be used, but often the most simple methods can be overlooked because they become routine. A discussion of some of the methods to locate follows and certainly should not be thought of as all inclusive. A sharp investigator will always pick up new ideas and devise new avenues of information.

(3) The name of a person to be located is usually always given by another person. By soliciting all available information from this source, the locating process can usually be greatly reduced. Such information as last known address, family relatives, friends, type of work, last employer, labor affiliates, habits, hobbies or outside activities, neighbors and a host of other information. Any information given may be of value later.

For instance, as a broad general rule, it is most logical to start looking for a person where he was last known to be living or working. It is very difficult to leave an area and not leave some type of thread behind as to where a person can be located. This thread starts where the person was last, and not to start there is generally poor judgment. As with all the information in this guide there is going to be an exception, but generally start where the person was last known to live or work.

As to the person's last residence, there are numerous possibilities. The landlord may have, or present tenant may have, information as to the person's whereabouts, or if the property is vacant and is for sale, the realtor may have pertinent information. The former neighbors of the person to be located often have information as to claimant's address or where he intended to go, and if nothing else, they can give a general direction to begin looking. A word of caution when talking to neighbors. If the investigator approaches the neighbors as if he were trying to locate "Public Enemy No. 1", then it is doubtful that these persons will co-operate. While it is not necessary to tell people everything we know, it is usually helpful to have an honest, sincere approach and usually if the person sought has information that relates to a case, then why not say this is the reason for trying to find the person, to help clear up certain aspects. It is not intended to imply that details of a case or other persons involved should be discussed.

(4) If it is known that a person is married and has school children then the school in the person's former area can be contacted. It is seldom that a child is ever moved without a transfer of school records. Even if the children are taken out of school without notice, they are soon enrolled at their new location. It is a consistent policy of school districts to write the former school district for past performance records.

(5) Let's take a look at where the missing person was last employed. Most employers use a rather comprehensive employment form and have other records which furnish a substantial amount of personal information. Do not overlook the fact that a fellow employee or immediate supervisor often has substantially more information than can be obtained from an official or even from records and can often lead to a direct location. As to office records, some of the information most pertinent is full name, date of birth, any physical descriptions, social security number, marital information, relatives or next of kin, previous employers or trades and union affiliates or any other information thought to be of some use.

If we know an individual belongs to a trade union, then probably the union will have information as to his location, or it is possible that he has asked for a travel card and can be located through this source. As to how much information an investigator can obtain from a union depends on the investigator, however, an honest approach will usually yield results. If union is reluctant to give out pertinent information, ask union official to have subject call you.

(6) If a person sought maintained a regular banking connection, it is possible that the person will have asked for a transfer of funds or if he had a loan on articles of value such as a vehicle, then it is most likely that the person received permission to move the property from the immediate area to the area of new location.

(7) In our contact with sources of information, it may be found

that a person has had some legal problem with the local authorities. The person may be on either State or Federal parole or probation and if so, this source is invaluable. If you do not know the local parole or probation officer, then check with the Office of Adult Probation & Parole in Olympia. This will usually bring the desired results. Do not overlook a check with local police and sheriff's office for this type of individual, and usually in the smaller communities the local law officials are a wealth of information.

(8) Probably one of the best sources of information is close relatives. A mother, father or even a recent girlfriend usually knows where a person can be located. Here again, do not approach these people with the idea that we are conducting a deep, dark investigation, but make your approach on a friendly, casual basis which is generally more adaptable to the work we are doing.

(9) There is another area of possible locate-help. If a person is indebted to private or public agencies, then contact with these agencies may well turn up a lead. Most of these agencies have trained collectors that do excellent locate work. Probably one of the best of the State agencies is the Support Enforcement Unit of our own department.

The investigator's personal contact with all of these agencies is most important and a cooperative attitude is a must.

(10) In this entire discussion, the simple and obvious avenue of information must not be overlooked. Many times an investigator will assume that an individual will be difficult to locate, therefore, he will attempt the more difficult approaches to the problem when a look in the phone book, reverse directory or a call to customers service of a public utilities company will get immediate results. Do not feel that the ideas discussed in this writing are the only methods to be used. Be alert, imaginative and obtain all of the information you can on an individual. It is seldom that an individual completely cuts all ties with family, friends or the community. Don't make a "big deal" out of this business. Most "locates" are a matter of going to the proper source of information and following through on this information.

D. Report Writing:

1. General -

The depth of your investigative reports and the exhibits required to substantiate their findings will, in most cases, be dictated by the type of action being taken as a result of your investigation.

If your case is to be referred for criminal prosecution, your report must be prepared in accordance with the guidelines established by the prosecutor or the trial deputy concerned. A case being returned to a local office VOCS unit for mandatory overpayment action does not require the same degree of documentation, however, all investigative reports must meet the basic test of answering six basic questions:

When?

Where?

Who?

What?

How?

Why?

Remember, the local office administrator or his representative must take action based on the content of your investigative report. Your report should be so complete that a person who had no previous knowledge of the case will gain a complete understanding of the case from your report.

Investigative reports involving departmental employees must be approved by the Director or in his absence the Assistant Director.

An outline of the type format to be followed in preparing investigative reports of this type is shown in Figure 3.

2. The Technique of Report Writing:

Report writing does not call for any degree of literary ability. A common-sense application to the business of getting essential facts down on paper is all that is required of the investigator. And always keep in mind that the best report has the fewest possible words. When revising your report, imagine that you have to send it by wire and that every word is costing you money. You will usually find that you can read through the draft of a report, cutting out here and there, and improving the report every time you omit a superfluous word.

(a) Essential elements:

Form: Heading

Address

Margin

Indentations

Signature

Matter: Logical arrangement

Division into paragraphs

Style: Grammar

Punctuation

Spelling

Capital letters

Smoothness and clarity

(b) Characteristics of a good report:

Completeness

Conciseness

Clearness

Attractiveness

Style

(c) Accuracy of the Report:

It should go without saying that accuracy is the prime requirement in the preparation of a report. Before attempting to write a report, the investigator should double-check on the full name of every person he has interviewed, and verify every official title or business name. Whenever in doubt, check the names of business firms or organizations with their listings in the telephone directory. The directory can be depended upon to give the exact name. Never try to guess at the spelling of a name from the way it sounds. If you don't think you will have an opportunity to check, ask the individual to spell it out.

(d) Style of a Good Report:

The report should be written objectively, avoiding any use of the first person "I". The investigator should refer to himself as "this investigator", "the undersigned", etc. Instead of writing "I interviewed John Doe", say "John Doe was interviewed".

Avoid the use of slang terms, which may have their place in detective fiction, but not in real-life reporting. If it is necessary to include a slang term in your report, isolate it with quotation marks. Likewise, avoid the use of technical terms which may be unfamiliar to readers of your report. If it is necessary to use a little-known technical term, immediately follow its first appearance with an explanation in parentheses.

Abbreviations should be watched. If a term is used in a report only once or twice, do not bother with the abbreviation. But if you find that you will be repeating a title several times, you may abbreviate it after the title has once been spelled out.

Use of proper nouns rather than pronouns will help to avoid confusion on the part of the reader. In any case, where a number of persons are mentioned in a report, the use of pronouns will be confusing and you should follow any questionable use of them with the name of the person being referred to in parentheses. For example, "He (Brown) indicated that Smith had been present."

Proper names in your report should be put down in capital letters, that is, the names of the persons, firms and organizations should be capitalized. This enables anyone looking through your report for a specific reference to find it easily.

Identify the source of any information before reporting the facts obtained from that source. In reporting an interview with a person, start that part of your report with the name of the person interviewed, then give the facts which the interview produced.

There are certain standard abbreviations which are used by most investigative agencies.

"A.k.a." following the title of a report indicates "also known as", and would be used to designate a nickname or some other name which the individual has used. Actually, the word "alias" has the same meaning but it has an unpleasant criminal connotation, and is therefore avoided.

"F.k.a." is used where a person has changed his name either legally, or by usage, and stands for "formerly known as".

"Nee" is used in a case involving a married woman. Her married name should be set down first, then "nee", then her maiden name. The word "nee" is from the French, and means "born".

3. Protection of the Report:

(a) Reports should be stored in locked, fireproof cabinets. Cabinets must always be locked when unattended.

(b) Only files which are actually in use are allowed outside the file cabinet.

(c) Reports and files must not be left on the desk when the investigator is interviewing or receiving anyone; no chance should be given an unauthorized person to read the material.

(d) Reports that must be mailed should be transmitted in double envelopes. The inside envelope should be marked "Confidential for" and the name of the party to whom the report is for. The outside envelope should be addressed like ordinary business mail with no unusual markings that would alert someone that a confidential report was inside.

4. Confidentiality of the Report:

The rules of confidentiality as outlined in Paragraph 74.04.060 of the Revised Code of Washington (RCW) is the basic statute to be followed regarding confidentiality.

Do not divulge information obtained during an investigation to anyone not authorized to have this information. If you are in doubt as to who is authorized to have information or read an investigative report, speak to your supervisor.

5. D.S.H.S. Employee Misconduct Reports:

Written reports on employee misconduct investigations generally follow the same format as used in welfare fraud cases involving an applicant or recipient.

An example of the format to be followed is shown in Figure 4. In addition to following this format, it is extremely important that all investigative reports involving an allegation against a departmental employee be in compliance with D.S.H.S. Policy No. 501.2 issued 11-14-74.

E. Sources of Information:

1. General - The sources of information available to the investigator include directories, indexes, file systems and persons having custody of public or private records which may furnish useful information in the course of an investigation.

There are few individuals or organizations on whom some records are not kept. The population has been classified into various groupings and records are available from many agencies and associations. Security requirements for employment on defense projects and in war plants since World War II have greatly expanded the scope of these sources, and the present day investigator with a working knowledge of sources of information has a big advantage over the pre-war investigator. The average citizen is unaware of the number of sources of information which can be tapped for data; this gives the trained investigator an advantage which he should exploit to the fullest.

2. The "Source" File:

One efficient way to record various sources is the keeping of a file, somewhat similar to the card directory in a library. Three 3 x 5 index cards should be made out for each source of information, and cards should be filed under three separate headings:

1. Type of information available;

2. Name of organization or record;

3. Name of individual who can supply the information.

If one organization has available different types of information, there should be a separate card filed for each type. It is a mistake to attempt to rely on memory to keep track of the many sources, and jottings on scraps of paper or notes in a pad or notebook are seldom worthwhile.

Upon receipt of an investigative assignment, the investigator should first sit down to think over the situation. He should analyze the problems involved and determine the type of information needed. He should consult his sources of information and list the places he must go to obtain the information. Then, he should plan his work and make sure the person to be interviewed knows he is coming. A half hour spent in planning can save hours or even days of running about.

Once the investigator has made a favorable contact with a source, he can often obtain desired information by telephone. It is vitally important to develop a personal relationship with individuals who can furnish him with information.

3. Reference Sources of Information:

Published directories are important sources of information. Among these are two books published by the telephone company which the general public is not aware of. In addition to the regular telephone and classified directories with which we are all familiar, the telephone companies also publish a "listing directory", which is not available to the general public. This volume contains a listing of all numbers in the local area, followed by the name of the subscriber. The numbers are arranged in order, which makes it possible to go from a number to the subscriber's name.

The "reverse directory" is a book which can be rented from the telephone company for a moderate fee. This lists telephone subscribers by street and number. In making any background or neighborhood check, this listing is invaluable.

a. City Directories:

Another important source of data on local residents is the city directory. Before the war, practically every city of any size had a directory, which was revised every two years. During the war, because of paper shortages and personnel problems, they were discontinued, but they are presently reappearing in most cities. The city directories are published by private companies which sell advertising in the rear section of the book. Prices for the book vary according to the size of the city, and run fairly high, but copies are available at public libraries, Chamber of Commerce offices, etc.

The city directories follow a standard format. The alphabetical directory (usually on white pages) lists all residents of the city 19 years of age or older, and all employed persons. Individuals and firms are listed alphabetically, including addresses, occupations, and in cases of married men, the wife's name in parentheses. A widow is also identified as such, with the name of her deceased husband. Names, ages and dates of death are listed for persons who were listed in the previous directory, and who died in the interim. Corporations, partnerships, and business firms are also listed.

In the numerical directory, (usually on pink paper) all the streets of the city are listed alphabetically or numerically, and the street number of each building is listed, with the occupants.

b. The Civil List:

Many cities publish annually a civil list, in which appears the names of all persons on the city payroll from the Mayor down. Generally arranged by departments, the civil list gives the name and address of each municipal employee, his or her job title, present salary, previous city positions held, dates of promotion, original date of entry into city service, etc. In cities where the civil list is not published, the data is usually a matter of public record, and may be obtained from card files in the offices of the Civil Service Commission or the payroll bureau.

c. Religious Directories and Year Books:

Almost every religious denomination issues an annual directory which lists the members of its clergy in the nation. Clergymen are listed alphabetically together with their assignments; also the geographical boundaries of church subdivisions, such as synods or dioceses, are given.

Since most persons, in filling out applications or reference forms, give a clergyman as a reference, this will assist the investigator in locating a pastor or minister who may have been listed by the subject.

d. Private Sources of Information:

There are many organizations in the business of keeping records on individuals and business firms, and their services are often valuable to the investigator, either by payment of a fee, or through a friendly relationship with someone in the firm.

In every sizable city, there is a Retail Credit Bureau which maintains extensive files on persons who have made any use of personal credit or charge accounts in the city, and these records will indicate the name of the individual and that of the wife or husband, place of employment or business, list of bank or charge accounts, and records of any judgments or bankruptcies, as well as a statement of the individual's credit rating and his assets.

Banks and loan and finance companies have valuable data on their accounts, and a friendly bank employee or official will often make this information available unofficially.

An Insurance Company Clearing House is maintained by the National Association of Life Underwriters, 11 West 42nd St., New York City, and here are kept records on all persons who have had or who now have any interest in a life insurance policy. Similar records are kept by the National Board of Fire Underwriters at 85 John St., New York City, with regards to persons who have an interest in fire insurance.

Mercantile agencies in every line of business publish directories which list all persons engaged in retail business together with their credit ratings and general information about their business standing. These will be discussed in later chapters.

e. Further Sources of Information:

Record sources - the following is a list and brief description of some frequently consulted sources of recorded information:

(1) Federal record. (a.) War Department. (b.) Office of the Adjutant General. The Adjutant General maintains records of all organizations, officers, and enlisted personnel that are or have been in the military service of the United States and also maintains such other records as authorized.

(2) Service, commands. The Security and Intelligence Divisions of the various service command headquarters maintain records which may be of assistance to the investigator.

(3) Provost marshals. Provost marshals at posts, camps, or stations, and at overseas establishments, maintain records which the investigator may consult.

(4) Navy Department. The Office of Naval Intelligence and the

several Naval District Intelligence Officers have information on the movements of travelers and ships, and on persons investigated by Naval Intelligence.

(5) Department of Justice. (a) The Federal Bureau of Investigation has on file fingerprint cards on many classes of persons, card indexes on all persons whose names have come to the attention of the FBI, and a complete scientific laboratory for analyzing and identifying criminal evidence.

(6) The Immigration and Naturalization Service has photographs, fingerprints, and brief biographies of aliens and immigrants, their residence and employment addresses, and the status of their naturalization. To aid in identifying the subject, the investigator should provide the Immigration & Naturalization Service with the name of the vessel, the date and the port of entry if this information can be obtained.

(7) Treasury Department Agencies have information relative to their respective functions, some of which are mentioned below.

(8) The United States Secret Service supresses counterfeiting and protects the person of the President.

(9) The Bureau of Narcotics investigates violations of the narcotic laws.

(10) The Intelligence Unit Bureau of Internal Revenue investigates violations of federal income tax laws.

(11) The Alcohol Tax Unit Bureau of Internal Revenue investigates violation of the laws relating to manufacture, storage, and sale of alcoholic beverages.

(12) The Bureau of Customs enforces the customs laws, supervises the importation of articles into the United States, patrols the borders of the United States, and apprehends smugglers.

(13) The Post Office Department will provide the investigator with all the information which appears on the outside of envelopes in the United States mail addressed to a particular individual. This service is known as a "mail cover" and will be continued for a specific period agreed upon by the investigator and the postal authorities. Mail may not be read except by censorship authorities or when seized pursuant to a search warrant. In securing a search warrant for mail the investigator should confer with the local postal inspector. At military establishments, the postal officer should be consulted for assistance.

f. Other federal agencies which have investigation units:

(1) Divisions of Investigations, Interior Department.

(2) Wages & Hours Division, Labor Department.

(3) Division of Investigation, U. S. Civil Service Commission.

g. The Veteran's Administration has information relating to former members of military and naval forces.

h. The United States Maritime Commission has records relating to the activities of the Merchant Marine and its officers and crews.

i. The Department of State has information relating to passports and visas.

j. The Federal Communications Commission investigates and reports on all organizations engaged in interstate radio or wire communication, and licenses and monitors all radio stations.

k. State, county, and municipal records: Among the various records which may have information of value to the investigator are those of the following:

(1) State police and highway patrols.

(2) Local police departments.

(3) State Attorney's Office.

(4) Sheriff's office.

(5) Fish and game wardens.

(6) County agent's office.

(7) Coroners or medical examiners.

(8) Fire marshals.

(9) City Attorney or City Prosecutor.

(10) Health, sanitation, building & license inspectors.

(11) Truant officers.

(12) Public welfare and social service agencies.

(13) Penal and probationary agencies.

(14) Courts.

(15) Tax assessors.

(16) Public and private schools, colleges and universities.

(17) County clerks, city clerks.

(18) Marriage license bureaus.

(19) Workmen's compensation boards.

1. Private Agencies:

(1) American Red Cross.

(2) Commercial credit bureaus maintain extensive files on persons who have made use of personal credit, and these include addresses, bank accounts, charge accounts, records of judgment, assets, and financial standing.

(3) Banks and loan and finance companies may have information relative to the financial transactions of the subject.

(4) Insurance Company Clearing House. The National Association of Life Underwriters, 11 West 42nd St., New York City, and various civilian credit agencies, have records on all persons who have or had an interest in life insurance policies. The National Board of Fire Underwriters, 85 John St., New York City, has the same information with regard to fire insurance.

(5) Railroad companies and their investigators are cooperative in furnishing information relative to the place of departure and destination of individuals and shipments.

(6) Bus lines maintain bills of lading at points of shipment and transfer points.

(7) Steamship companies and air lines usually have records of the names and addresses of passengers, the dates of travel, the point of disembarkation for each passenger, and the reservations made for land transportation or hotel accomodations.

(8) Telephone companies records of long distance calls show the number calling and the city and number called. On certain calls, the name of the caller and the name and address of the person called are recorded.

(9) Telegraph companies have records and copies of telegrams and money orders.

(10) Water, electric, and gas companies are often the first agencies to obtain the addresses of persons newly arrived in a city.

(11) Newspaper files, commonly called "morgues", disclose the extent and type of publicity which an individual has received.

(12) Real estate agencies, have information concerning their tenants.

(13) Automobile associations can furnish information regarding the registration and ownership of members'automobiles.

(14) Hospitals keep records of wounds, injuries, illnesses, scars, births and deaths.

(15) Hotel associations maintain files on criminals, such as bad check passers, card sharks, and confidence men. By inquiring at the association's office, the investigator may learn about any guest of a member hotel.

m. Miscellaneous:

(1) Telephone directories ordinarily are arranged according to the names of the subscribers or according to the business of the subscriber. Special telephone directories are compiled for large business and other agencies, arranged according to street addresses.

(2) City directories furnish addresses, occupations, names, and members of families living in the city at the time the information for the directory was collected. Early editions will reveal the year a person moved into the locality, former address, and occupations.

F. The Knowledge and Use of Evidence:

1. General - You have often heard the statement, "If you want to win the game you have to know the rules". This simple statement is equally valid in a poker game, a basketball game or the successful prosecution of a welfare fraud case.

The investigator who knows what evidence can be used by a trial deputy in court is not going to "build" his case around evidence that is inadmissible in court. This section of the manual is not intended to qualify you as experts in the field of criminal law. However, your knowledge of the rules of evidence, the kinds of evidence, and how to present evidence in court, are all tools which every good investigator must possess to be successful.

2. Admissible evidence - Res Gestae: Res Gestae, meaning the things done, is a rule of evidence which states that all declarations, statements and acts involved in the transaction and which help to explain and make clear what occurred are admitted in evidence. It does not refer only to the criminal transaction itself, but is used in referring to any transaction related to the proof. For instance, circumstances attending the purchase of equipment, materials or supplies preparatory to smuggling enterprises or counterfeiting operations, may properly be included in the term res gestae. Such facts are admissible evidence.

3. Admissions and confessions: Admissions and confessions are declarations of the defendant which tend to prove his guilt. An admission is an acknowledgement of a fact which, together with the other facts, tends to prove the defendant guilty. On the other hand, a confession is a statement which expressly admits guilt. It may be oral or written. An admission is received in evidence whether or not it is made voluntarily, but a confession must be proved to have been made voluntarily, without force or fear in order to be accepted in evidence. A defendant who is charged with the violation of a Federal law should be informed of his rights before a confession is received from him, for a confession freely made may be used against the criminal. No promise of immunity, or a lesser sentence, or suggestion that the defendant will be benefitted in any way can be made in order to induce a confession. There must be no threat from anyone in authority. If a confession is freely made, it is admissible even if the defendant was partly under the influence of liquor at the time of the confession.

4. Threats, self-serving, and accusatory statements: Evidence of threats is admissible to show intent or motive. Any fact which supplies a motive for an act is relevant. Statements made by the defendant subsequent to the crime in his own favor are deemed self-serving and are inadmissible when offered by the defense, for they are heresay and incompetent. But if such statements have any tendency to prove the guilt of the defendant they may be introduced by the prosecution. If an accused has an opportunity to reply to an incriminating statement made in his presence, but is silent or makes a false statement, the accusation may be admissible in evidence against him. Any statement or conduct indicating a consciousness of

guilt is admissible, including, for example, the attempt to bribe an officer or possible witness, an assault on the arresting officer or his aides, giving a false name at the time of arrest, false statements with reference to the charge against the defendant.

5. Acts and statements of conspirators: Such acts are binding on all conspirators. This rule is analogous to a legal partnership in which the acts of one partner within the scope of the business in which they are engaged, are binding on his copartner. Testimony in such cases is admissible only after proof of the existence and object of the conspiracy.

6. Expert evidence: Such evidence is admissible when presented by those who are specialists in a particular field. For instance, opinions of physicians, chemists, handwriting experts are admissible because they have expert knowledge of a special science or trade, or process. If an opinion of an expert is proved erroneous it tends to discredit his entire testimony. Experiments may be introduced, but to be admissible in evidence they must be carried out under conditions which are similar to the actual event. The conditions need not be absolutely identical, but there must be no change of conditions which could have any effect on the result of the experiment.

7. Documentary evidence: Account books are admissible, if they are books of original entry, are regular and continuous and if the entries were made at or near the time of the occurrance of the transaction recorded. Proof is generally required as to the correctness of the entry by the person having personal knowledge of it. Documents kept by the public officer in the course of his duty, and coming from proper custody are admissible in evidence. Copies of public documents are regarded as equivalent to the originals if they are duly authenticated. Such records may include a register of vital statistics, stock brands, land, registers of conveyances, and judicial records. In addition, there are certain quasi-public documents which are generally considered admissible upon identification, e.g., standard morality tables, tide tables, and astronomical calculations.

8. Character evidence: Witnesses may be presented by the defendant in a criminal prosecution to establish his good reputation in the community. The evidence emphasizes special traits, such as honesty, integrity, peaceable nature, implying that a person of such reputation is not likely to commit the crime charged against him. Such evidence can only be introduced in the first instance by the defendant, but after that the prosecution may introduce character witnesses to prove the bad reputation of the defendant. Either party may impugn the credibility of witnesses on the other side by proving that the witness has been guilty of a crime, or has made previous statements contrary to his testimony, or that his attitude in the case is unduly favorable or hostile. Evidence may be introduced to prove that the witness was incompetent to observe accurately.

It is for the cross-examiner to test the witnesses of the other party with respect to the value of their statements, the strength of their recollection and their disposition to tell the truth.

9. Kinds of Evidence:

a. Circumstantial evidence: This form of evidence includes facts and circumstances from which an inference may be drawn as to the existence of the fact to be established. It is evidence which tends to prove a disputed fact by proof of other facts which have a legitimate tendency because of the usual connection of things, or the ordinary transaction of business, or from the laws of nature. The judge and jury draw conclusions from circumstantial evidence and find one fact from the existence of other facts shown to them.

b. Corroborative evidence: This consists of additional evidence on the same point as the one already given. After an attempt to impeach the credibility of a witness has been made, he may be corroborated by explanations or denials where an attempt has been made to impeach by evidence of malice, bias, or interest. Corroboration by other evidence is always permitted in such cases.

c. Hearsay evidence: Such evidence consists of statements made by some other person with respect to a past transaction, or with respect to what the witness himself has related in the past to some other person. It depends, in part, on the competency and veracity of some other person. As a general rule hearsay evidence is not admissible. The reason is that a person who knows a fact should be brought into court to state his evidence under oath. The hearsay rule applies to written as well as to oral statements. There are exceptions to this rule which are admissible. For example, dying declarations and admissions and confessions.

d. Direct evidence: This is evidence of a witness who testifies as to his actual knowledge of the facts to be proved. It tends to show the existence of a fact in question without the intervention of the proof of any other fact.

e. Relevant evidence: This is a term applied to evidence that bears some relation to the facts at issue.

f. Material evidence: Such evidence tends to establish some fact that is in dispute.

g. Competent evidence: This is evidence which is proof of the fact at issue in a case.

h. Opinion evidence: This may be expert or non-expert opinion. Reference has already been made to the nature and admissibility of expert opinion. Non-expert opinion is that of an ordinary witness who has personally observed the facts on the basis of which an opinion is expressed.

i. Exhibits: These include all objects gathered to be used as evidence at the trial. Such articles to be evidence must be directly related to the facts at issue. Documents as evidence have already been mentioned. Another group of exhibits used as evidence includes "demonstrative" or "real" evidence which can be presented directly to the senses of court or jury without an intervening medium or proof. Real evidence is the object itself. It has certain observable qualities. "Representative real evidence" includes such exhibits as X-ray photographs, charts, diagrams, sketches, models, etc. Such evidence is admissible if it is duly authenticated as being correct as a representation. Experiments are included in this category of evidence.

j. Parol evidence: Such evidence is presented by word of mouth, or orally as testimony of witnesses. It is not a substitute for or equivalent to a written instrument where the latter is required by law, but parol evidence is admissible to defeat a written instrument on the ground of fraud.

10. Presenting Evidence in Court:

The trial is the culmination of the investigator's work. The investigator is naturally interested in having his evidence presented in the best possible manner. The case should not be prejudiced by an unconscious action on his part.

A proper personal appearance helps make a favorable impression. The agent should be neatly dressed and should act in a gentlemanly manner. Chewing gum audibly or using a toothpick do not help in creating the desired impression. The behavior of the investigator in court should not be such as to convey the thought that he is over-eager to secure a conviction. If he has done his work properly, there is no need for him to disturb the proceedings by giving the prosecutor some last bit of information or to suggest some question that should be asked of the witness on the stand. Such behavior distracts the attention of the prosecuting attorney from the testimony that is being offered at the time and from the conduct of the case. If it should be necessary to convey some information, it should be done as unobtrusively as possible by writing the information or suggestion and conveying it to the attorney. The investigator should not show any reaction of approval or displeasure when any testimony is given from the stand.

On the witness stand, the agent tells frankly whether he does or does not remember information that is asked for. He may be given permission to use his notes. He should be quiet, reserved and natural. He should talk distinctly and avoid slang. Technical terms should be explained. Answers should be definite and frank. If the cross-examination is vigorous, the agent should not argue with defendant's counsel. He should continue in a definite but courteous manner, so as to make a favorable impression on the jury.

11. Chain of evidence:

When physical evidence pertinent to a crime is found or recovered, there are certain rules to be followed in the handling of this evidence and its preparation for presentation in court or transmittal to a laboratory if technical assistance is necessary. The important rules are:

(1) Mark or label the evidence in such a manner that at any later date it can be identified positively as the evidence taken in connection with the crime under investigation.

(2) When presented in court all evidence must be accounted for from the time it was found and it must be uncontaminated and unchanged in character. This procedure is known as the "chain of evidence". This chain must be unbroken from the time the evidence is first obtained by the investigator until it is offered in court.

G. The "Portrait Parle":

The discription of people presents a problem to the average individual; that is, he may be able to "see" the person he is attempting to describe in his mind's eye, but may be unable to translate that picture into words. In this case, the investigator will find the "portrait parle", or spoken picture technique a help (the same technique should be used in describing an individual to another investigator).

Often, a helpful witness will say "That's it!" as the investigator brings the proper descriptive term to his attention.

A proper physical description should include the following items:

1. Height and Weight: Here, the investigator may find comparison useful. Use other persons as standards of comparison. Such questions as "Was he about my height?" "Was he as stout as the man in the grey suit?" "Did he look older than the man we saw in the hall?", etc., may bring a definite "fix" to the witness' mind.

2. Build: Large, medium, small, stocky, fat, slim.

3. Posture: Erect, stooped, slumped, stiff, loose.

4. Complexion: Rough, smooth, tanned, dark, freckled, pale, fair, sallow, florid, pock-marked.

5. Head: Long, short, broad, narrow, large, medium, small, square, round; inclined forward, backward or sideways.

6. Hair: Black, brown, auburn, blond, red, grey, white, thick,

thin, kinky, wavy, curled, straight, parted; frontal, back or complete baldness.

8. Mustache or beard: Short, medium, long; color, pointed or dull ends, turned up or down, straight; thick or thin, type of beard or sideburns.

9. Forehead: Broad, narrow, high, low, receeding, vertical, protruding or bulging.

10. Eyebrows: Thin, bushy, penciled, natural, arched, horizontal, slanting up or down, meeting.

11. Eyes: Blue, brown, yellow, grey, green; clear, bloodshot, jaundiced; straight, oblique, cross-eyed, squinting, narrow, wide, close-set, widely separated; piercing, dull, fixed, mobile; eyelashes long or short; type of glasses.

12. Ears: Small, medium, large; close to head or projecting; oval, round, rectangular, triangular, cauliflower or pierced; hairy or not hairy; lobe-descending, square, medium, gulfed.

13. Cheeks: Full, fleshy, sunken.

14. Cheekbones: High, low, prominent, or not prominent.

15. Nose: Long, medium, short; thick, thin, concave, straight, convex, Roman, pointed or flat, turned up or down, horizontal, turned to left or right; nostrils large, small, high, low, flared.

16. Mouth: Turned up or down at the corners; held open or closed, distorted by speech or laughter.

17. Lips: Thick, thin, puffy; overhanging, pendant, compressed, protruding, retracted over teeth; color-pale, bright, unusual.

18. Teeth: Yellow, white, dull, stained; firm, loose, decayed, filled (color of filling), braced, broken, capped, receding or projecting, false.

19. Chin: Small, large, square, curved, pointed, flat, dimpled, double, jutting or protruding, vertical or normal, receding.

20. Jaw: Long, short, wide, narrow, thin, fleshy, delicate or heavy.

21. Neck: Short, long, straight, curved, thin, fat, prominent, medium or absent Adam's apple.

22. Shoulder: Small, heavy, narrow, broad, square, round, one higher or lower, stooped.

23. Waist: Small, medium, large.

24. Stomach: Flat, bulging, flabby, firm.

25. Hands: Long, short, broad, narrow, thin, soft, fleshy, bony, rough; color: smooth, hairy; square, tapered.

26. Fingers: Short, long, slim, thick, tapered, square, nicotine-stained, missing digits.

27. Walk: Slow, fast, stride long or short.

28. Dress: Conservative, loud, neat, slovenly.

29. Distinctive marks: Scars, birthmarks, amputations, tattoos, bow-legs, knock-knees, lameness, habitual mannerisms.

V. Personal Conduct:

A. As investigators for the Washington State Department of Social & Health Services, we have daily contact with recipients, professional organizations, the business community, law enforcement agencies, and the general public. Therefore, it is of paramount importance that as individuals and as an organization, our actions be professional, efficient and courteous. There is no place or need for using devious means to obtain information. A "forthright" approach is the best approach. The manner in which you act and the methods you use must always be carried out to avoid any future embarassment to the department and to yourself. Deception is too dangerous. If you practice it, even indirectly (by such things as implying that something is not true, without actually saying it) you may open yourself to criticism. If at any time you are assigned a case involving a person who is a relative to you by blood or marriage, a close friend, acquaintance or who is a close friend or acquaintance of your immediate family, you will reveal these facts to your supervisor for a decision on the possible reassignment of that case to another investigator. In your job, you will be required to appear as a witness in court very often; it is essential that your conduct be above attack.

B. Always observe the rules of confidentiality, as outlined in paragraph 74.04.060 of the Revised Code of Washington (RCW). To be a good investigator, you must be a good listener. Do not divulge information obtained from a witness to the person being investigated, another witness, or other contacts during your investigation.

C. Male investigators will not conduct field interviews with female recipients without a third party selected by the investigator being present.

D. Departmental policy prohibits the carrying of firearms in the performance of duties as an OSI investigator.

E. Public assistance case files (financial & service) will not be removed from a local office without the specific approval of the local office administrator or his designated representative. This does not preclude an investigator making copies of material in these records that are pertinent to a case being investigated.

F. Written communications expressing SIS policy, procedures, training, and use of collateral resources must have prior approval by the Director or Deputy Director and in most cases should be signed by them personally.

G. No investigator shall accept a work assignment nor perform any investigation for an agency other than D.S.H.S. without prior approval of the Director, or Deputy Director or his Field Office Supervisor.

VI. Telephone Credit Card Usage:

Your telephone credit card is issued to you for use in conjunction with your duties as a member of the Special Investigative Section and is to be used for official state business only, when a SCAN or WATS line is not available. You will be held accountable for all calls charged to your telephone credit card and should be prepared to justify these calls if required.

The telephone credit card is an investigative tool. Like any tool, it is most effective when used efficiently and correctly.

VII. Travel Expense Vouchers:

A. General - With the knowledge that all travel expense vouchers are subject to audit at any time, the following internal controls are established to insure standard procedures for substantiating and claiming travel expenses are followed by all assigned personnel:

1. The required procedures and forms to be used by staff required to be on travel status or engage in field work are set forth in Chapter 7, D.S.H.S. Management Service Guide. If further detail is necessary, you may consult the D.S.H.S. Travel Policy No. 257-T.

2. A personal record of all reimbursable travel expenses will be kept to substantiate any claim for reimbursement. This record should include the date or dates of travel, reason for travel, miles actually traveled, (by odometer reading or D.S.H.S. mileage chart). A copy of receipts for all claimed expenses; i.e., motel bills, taxi fares, parking fees, etc.

3. Travel expense vouchers will be completed and turned in the first working day of each month. The vouchers will be checked for accuracy and typed by designated clerical personnel. They will be reviewed and signed by the responsible supervisor no later than the third working day of each month. All travel expense vouchers should be received in the State Office Headquarters, no later than the sixth working day of each month.

B. Travel Limitations:

VII. Travel Expense Vouchers - continued

1. Personnel traveling within the Olympia, Tacoma and Seattle area must familiarize themselves with the restrictions of the Deputy Secretary's memorandum of March 7, 1974: Subject: Use of Private, Pool, Permanently Assigned, and Agency-owned Vehicles Within the Olympia, Tacoma and Seattle area.

2. Any daily trips involving more than 40 miles will be approved by your supervisor at least one day prior to the trip. Supervisors will insure that as many cases as possible are worked on when trips over 40 miles are authorized.

3. Whenever possible, clients will be asked by letter or phone to come into the field office for interviews. This not only cuts down the amount of mileage per investigator, but also provides the most advantageous setting for interviews of this type.

VIII. Equipment Control:

A. General - In keeping with accepted good management practices, it is necessary to maintain an equipment control system. The implication of this system will allow us to maintain an equipment master file by location of every piece of equipment assigned to the Special Investigative Section.

B. The following action will be taken by the Assistant Director for the State Office Headquarters and by the Regional Field Office Supervisors for their Regional Field Offices:

1. Take a physical inventory of every piece of equipment you have on hand.

2. Prepare two 5" x 8" cards for each piece of equipment giving a description of the equipment, the location to which assigned, (by Field Office or Hq.) and the State tag number attached to the equipment. If any piece of equipment does not have a state tag attached indicate this by a pencil notation on the 5"x8" file cards.

3. Disposition of the 5" x 8" file cards will be as follows:

    a. File the original in the field office equipment file;

    b. Send the duplicate copy to the S.I.S. State Office Headquarters for inclusion in the equipment master file.

    c. Lost or damaged equipment will be reported to S.I.S. State Office Headquarters by memo as soon as the loss or damage takes place. In addition, when loss or damage takes place, an entry will be made on the original copy of the 5" x 8" inventory control card indicating the date loss or damage was discovered and an entry indicating the date that S.I.S. State Office Hq. was notified.

d. An inventory verification will be taken once a year between the 1st & 15th of January. The date of the inventory verification will be entered on the inventory control card and initialed by the person who made the inventory verification. S.I.S. State Office Hq. will be notified by memo when the yearly inventory verification has been completed.

e. The movement of any equipment between field offices must have prior approval in writing from the Director or Assistant Director. When equipment is moved from one field office to another, the inventory control card must accompany the equipment.

IX. Public Information Policy:

A. General - Departmental policy is outlined in Public Information Policy No. 121.1 as amended on 10/24/73.

B. Initiation of contact with the representatives of the mass media; i.e., radio, TV, newspapers, etc. will be handled by the Director of S.I.S. or his designated representative.

C. The department's Public Affairs Officer handles regular news releases pertaining to monthly fraud statistics in coordination with the Director of S.I.S. Field Office Supervisors may be asked by the news media to respond to specific questions from time to time. While it is not possible to pre-guess what those questions might be, some general guidelines are as follows:

1. New policy or policy change questions should not be answered before checking with the Director or Assistant Director to insure you have up-to-date and accurate information.

2. Questions involving a case that has been referred for criminal prosecution should be answered by the prosecutor's office and not by S.I.S.

3. Field Office Supervisors will insure that they as well as all members or their staff have read and are familiar with the Department's public information policy.

UNIFORM PRESENTATION OF THE WRITTEN WORD

As an aid to the uniform presentation of the written word in the preparation of investigative reports, the following guidelines are established for the guidance and benefit of the investigative staff:

ABBREVIATIONS

First mention of organizations, firms, agencies, groups, etc. should be spelled out.

Distant Early Warning line (DEW line).

Abbreviate business firms: Warner Bros.; Brown Implement Co., Amalgamated Leather, Ltd.; Smith & Co., Inc.

Abbreviate St., Ave., Blvd., Ter., in addresses but not Point, Port, Circle, Plaza, Place, Drive, Oval, Road, Lane. Examples: 16 E. 72nd St. (single "E" with period); 16 Gregory Ave. NW (no periods in "NW"); Sunset Boulevard, Main Street, Fifth Avenue (no addresses.)

Lower case abbreviations usually take periods. The rule of thumb is if the letters without periods spell words, periods are needed. Examples: c.o.d., f.o.b., etc. However, m.p.h., a.m., p.m.

Abbreviate versus as vs. (with period).

Abbreviate titles and capitalize: Mr., Mrs., M., Mlle, Dr., Prof., Sen., Rep., Asst., Lt. Gov., Gov. Gen., Supt., Atty. Gen., Dist Atty., in titles before names but not after names. Do not abbreviate attorney in: The statement by defense attorney John Jones, etc.

CAPITALIZATION

Capitalize titles preceding a name: Secretary of State John Foster Dulles. LOWER CASE title standing alone or following a name: John Foster Dulles, secretary of state.

Capitalize government officials when used with name as title: Queen Elizabeth II, Premier Debre, etc. LOWER CASE when standing alone or following a name: Debre, premier of France.

Capitalize titles of authority before name but LOWER CASE standing alone or following a name: Ambassador John Jones; Jones, ambassador; the ambassador.

Long titles should follow a name: John Jones, executive director of the commercial department of Blank & Co. Richard Roe, secretary-treasurer, Blank & Co.

LOWER CASE occupational or "false" titles such as day laborer John Jones, rookie left-handed pitcher Bill Wills, defense attorney John Jones.

CAPITALIZE Social Security (Administration, Act) when referring to U.S. system: He was receiving Social Security payments. LOWER CASE use in general sense: He was an advocate of social security for old age.

CAPITALIZE U.S. armed forces: Army (USA), Air Force (USAF), Navy (USN), Marines (USMC), Coast Guard, National Guard.

CAPITALIZE specific regions: Middle East, Mideast, Middle West, Midwest, Upper Peninsula (Michigan), Southern (Illinois, California) Texas (Oklahoma) Panhandle, Orient, Chicago's near South Side, Loop, etc.

LOWER CASE Mere direction: Snow fell in western North Dakota.

CAPITALIZE names of races: Caucasian, Chinese, Negro, Indian, etc. LOWER CASE black, white, red. Identification by race should be made when it is pertinent.

CAPITALIZE common noun as part of formal name: Hoover Dam, Missouri River, Barr County Courthouse. LOWER CASE dam, river, courthouse, etc., standing alone. CAPITALIZE Empire State Building, Blue Room, Carlton House (hotel), Carlton house (home), Wall Street, Hollywood Boulevard. Plurals would be : Broad and Main streets.

CAPITALIZE names of organizations, expositions, etc., Boy Scouts, Red Cross, World's Fair, Iowa State Fair but LOWER CASE scout, fair standing alone.

PUNCTUATION

Punctuation in writing serves the same purpose as voice inflection in speaking. Proper phrasing avoids ambiguity, insures clarity and lessens need for punctuation.

The Period

The period is used after a declarative or imperative sentence: The facing is Vermont marble. Shut the door.

The period is used after a question intended as a suggestion: Tell how it was done.

The period is used in summary form: 1. Korean War. 2. Domestic policy. A. Punctuate properly. B. Write simply.

The period is used for ellipsis and in some columnist material.
Ellipsis: The combine...was secure.
Column: Esther Williams gets the role...John Hay signed a new contract.
Rephrasing to avoid ellipses is preferable.

The period is used in abbreviations: U. S., U. N., c.o.d., etc.

The period separates integer and decimal: 3.75 per cent; $8.25; 1.25 meters.

The period is omitted after a letter casually used as a name, and where a person omits the period in his name: A said to B that he was not watching. Herman B Wells (his usage).

The Comma

The comma separates words or figures:
What the solution is, is a question.
Aug. 1, 1960   1,234,567
The comma serves in a series:
The woman was short, slender, blonde, well-dressed and old.
x, y and z.   1, 2 and 3.
The Selma, Ala., group saw the governor.

Do not use comma before "of": Brown of Arkadelphia.

Newspaper usage has, in most cases, eliminated the comma before "and" and "or" but this practice does not lessen the need for the mark in:
Fish abounded in the lake, and the shore was lined with deer.

The comma is used to set off attribution: The work, he said, is exacting. It is used in scores: Milwaukee 6, St. Louis 5.

The comma is used to separate in apposition or contrast:
Smithwick, the favorite, won handily.
But: The car that failed has been ahead.

The comma is omitted before Roman numerals, Jr., Sr., the ampersand, dash, in street addresses, telephone numbers and serial numbers: Louis XVI, John Jones Jr., Smith & Co., ORegon 3-3617, 12345 Oak St., A1234567. (See 4.4)

The Semicolon

The semicolon separates phrases containing commas to avoid confusion, and separates statements of contrast and statements too closely related:
The draperies, which were ornate, displeased me; the walls, light blue, were pleasing.
The party consisted of B. M. Jordan, R. J. Kelly, his secretary; Mrs. Jordan; Martha Brown, her nurse; and three servants. (Without the semicolons, that could be read as nine persons.)

The Apostrophe

The apostrophe indicates the possessive case of nouns, omission of figures, and contractions.

Usually the possessive of a singular noun not ending in "s" is formed by adding the apostrophe and "s"; the plural noun by adding the "s" and then the apostrophe: boys' wear, men's wear.

The apostrophe is also used in the plural possessive "es"; Joneses' house.

The "s" is dropped and only the apostrophe used in "for conscience' sake" or in a sibilant double or triple "s" as "Moses' tables."

In single letters: A's.

The apostrophe is used in contractions: I've, isn't, in omission of figures: '90, '90s, class of '22.

The apostrophe use or lack of should follow the official name of group, institution, locality, etc.: Johns Hopkins University, Actors Equity Association, Court of St. James's (variation of possessive ending).

The Colon

The colon precedes the final clause summarizing prior matter; introduces listings, statements and texts; marks discontinuity, and takes the place of an implied "for instance":

The question came up: What does he want to do?
States and funds allotted were: Alabama $6,000; Arizona $4,000, etc.

The colon is used in clock time: 8:15 p.m.

The colon is used in Bible and legal citations: Matt 2:14.
Missouri Statutes 3: 245-260

The Exclamation Point

The exclamation point is used to indicate surprise, appeal, incredulity or other strong emotion:
How wonderful! What! He yelled, "Come here!"

The Question Mark

The question mark follows a direct question, marks a gap or uncertainty and in the latter use is enclosed in parentheses:

What happened to Jones?
It was April 13 (?) that I saw him.

The mark also is used in public proceedings, interviews, etc.:
Q. Were you there? A. I don't recall.

Exception: Where, in interviews, the question or answer is of some length, it is preferable to paragraph both Q. and A.

Parentheses

Parentheses set off material, or an element of a sentence.
It is not the custom (at least in the areas mentioned) to stand at attention.

Where location identification is needed but is not part of the official name: The Springfield (Ohio) Historical Society edition, etc. It is not necessary to bracket: The Springfield, Ohio, area population, etc.

Parentheses are not used around political-geographical designation: Sen. Theodore Francis Green, D-R.I., and Rep. Charles A. Halleck, R-Ind., were invited.

Parentheses set off letters or figures in a series: The order of importance will be (a) general acceptance, (b) costs, and (c) opposition.

Where part of a sentence is parenthetical and the punctuation mark comes at the end of the sentence it goes outside:

He habitually uses two words incorrectly (practical and practicable).

Ordinarily the mark goes inside: (The foregoing was taken from an essay.)

Several paragraphs of parenthetical matter start with the opening mark on each paragraph and the final paragraph is ended with a closing parenthesis with the punctuation inside.

Quotation Marks

Quotation marks enclose direct quotations; are used around phrases in ironical uses; around slang expressions; misnomers; titles of books, plays, poems, songs, lectures or speeches when the full title is used; hymns; movies; TV programs, etc.

Use quotation marks instead of parentheses around nicknames apart from the name: Smith, who weighed 280, was called "Slim".

Harold "Red" Grange.

The comma and period are placed inside the quotation marks. Other punctuation is placed according to the construction:

Why call it a "gentlemen's agreement"?

The sequence in multiple quotations:

"The question is 'Does his position violate the "gentlemen's 'post-haste' agreement" so eloquently described by my colleague as "tommyrot"?'"

The Dash

The dash indicates a sudden change. Examples:
He claimed-no one denied it-that he had priority.
It can be used instead of parentheses in many cases: 10 pounds-$28-paid.

If that man should gain control-God forbid!-our troubles will have only begun.

The monarch-shall we call him a knave or a fool?-approved it.

The Hyphen

The hyphen is one of the least correctly used, and most abused, marks. It is used properly to form compound words, to divide words in composition, in figures, in some abbreviations, and to separate the double vowels in some cases.

The general rule for hyphens is that "like" characters take the hyphen, "unlike" characters do not.

A-bomb, U-boat, 20-20 vision, 3D, B60, MIG17, 3-2 (odds and scores), secretary-treasurer, south-southwest, north-central.

Exception: 4-H Club.

Ordinarily in prefixes ending in vowels and followed by the same vowel, the hyphen is used: pre-empt, re-elect. (Check dictionary for exceptions such as cooperate, coed, coordinates, etc.)

NEVER use the hyphen with adverb ending in "ly" such as badly damaged, fully informed, newly chosen, etc.

The hyphen also serves to distinguish meaning of similiarly spelled words: recover, re-cover, resent, re-sent.

The hyphen also separates a prefix from a proper noun: pre-Raphaelite, un-American, etc.

The prefix "ex" is hyphenated: ex-champion.

The hyphen has been abandoned in newspaper usage in weekend, worldwide, nationwide, etc.

The Ampersand

The ampersand is used in abbreviations and firm names: Jones & Co., AT&T, etc.

Spelling

Often used and frequently misspelled: (*preferred spelling)

adviser
accommodate
anyone
Asian flu
ax
baby-sit
baby sitter
baby-sitting
baritone
blond, male
blonde, female hue
box office
box-office sales
cannot

consul
copilot
copter
council
counsel
disc
drought
drunken
employe*
embarrass
eyewitness
fallout
fire fighter
fulfill

hitchiker
homemade
home town
impostor
ionosphere
isotope
judgment
jukebox
kidnaping
likable
machine gun
missile
naptha
old-timer

restaurant
rock'n'roll
schoolteacher
sit-down
skillful
strait jacket
strong-arm
subpoena
swastika
teen-age
under way
vacuum
wash'n'wear
weird

cave-in
chauffeur
cigarette
clue
consensus
goodby*
good will, noun
goodwill, adj.
hanged
harass
per cent
percentage
permissible
post office
propeller
wheel chair
whisky
wiretapping
X ray, noun
X-ray, adj.

LEGAL DEFINITIONS

ABDUCTION: The unlawful act of taking away a virgin, a wife, or a widow against her will.

ABSCOND: To hide from the jurisdiction of a court in order to avoid a legal process.

ACCESSORY BEFORE THE FACT: One who helps another to commit a crime, even though he is absent when the crime is committed.

ACCESSORY AFTER THE FACT: One who harbors, assists, or protects another person although he knows that that other person has committed a crime.

ACCOMMODATION PAPER: A bill of note to which someone has signed his name, without having been paid to do so, for the purpose of benefitting or accommodating some other party who desires to raise money on the paper.

ACKNOWLEDGMENT: The act by which a party goes before a competent officer or court and declares that he has voluntarily performed a certain deed.

ACQUIT: To free a person legally from an accusation of criminal guilt.

ACTION: An ordinary proceeding wherein one party seeks to uphold his rights under the law.

ACTION TO QUIET TITLE: A proceeding in which the plaintiff declares that the defendant has been claiming some ownership in the plaintiff's land without defining the nature of that ownership. The action calls for definition so that the matter may be settled by decree.

ADJOURNMENT: Postponing a session or a hearing to some other time or place.

ADMINISTRATIONS OF ESTATES: The management and settlement of the estate of an intestate or a testator who has named no executor. The work is done under the jurisdiction and supervision of the courts by a legally appointed administrator.

ADMINISTRATOR, LETTERS OF: Issued by probate court, they empower the administrator to take charge of an intestate's affairs.

ADULT: Any person who is twenty-one years of age or over.

ADULTERY: Voluntary and unlawful sexual intercourse between a man and a woman, at least one of whom is married.

ALIMONY: An allowance paid by a husband for his wife's support when she is living separate from him. Such an allowance is usually made during and after a suit for divorce.

AFFIDAVIT: A written or printed declaration or statement of facts, made voluntarily, and confirmed by the oath or affirmation of the party making it, taken before an officer having authority to administe such oath.

ANCILLARY: Aid, auxiliary; used to describe an action which is dependent upon a principal proceeding.

APPEAL: A case carried to a higher court, in which it is asked that the decision of the lower court, in which the case originated, be altered or over-ruled completely.

APPENDIX A

ARBITRATION: The settlement of a disagreement out of court by an arbitrator chosen by the parties to the argument. The parties agree that they will adhere to the arbitrator's decision.

ARRAIGN: To cause a person to stand trial for the charge in an indictment.

ARREST: To deprive a person of his liberty by legal authority that he may be held to answer for a crime.

ARREST, ORDER OF: A "provisional remedy" which may be employed in certain civil actions to prevent the object of the action being defeated by the defendant fleeing from the jurisdiction of the court before judgment. The order of arrest secures indemnity for the wrong committed, either by holding the defendant personally until the judgment is rendered or by requiring bail for this purpose.

ARSON: Wilfully and maliciously burning property.

ASSAULT: An unlawful attempt to hurt another person physically. Should the person actually be beaten then the act is called "Battery".

ATTACHMENT: This is a proceeding for the seizure of the property of the defendant before judgment and as such it is classified as a "provisional remedy." It cannot exist except as an aid to the action in which it is obtained. The purpose is to obtain possession of property until the recovery of a judgment and thereby prevent the defendant from disposing of it to defeat the object of the action in which the attachment is granted.

ATTAINDER, BILL OF: Is an act passed by the legislature for a special purpose of pronouncing a person guilty of an alleged crime (usually treason) without trial or conviction and passing sentence of death and attainder (deprivation of all civil rights and forfeiture of land) upon him. Bills of attainder are probitited by the United States Constitution.

ATTESTATION: Witnessing an instrument in writing and recording that act in writing on the instrument.

BAIL: To release a person from jail by guaranteeing that he shall ramain within the jurisdiction and call of the court. The bail bond which must be posted in a sum usually proportioned to the seriousness of the crime, and it may be forfeit if the defendant does not appear when called.

BEQUEST: A gift of personal property by will.

BIGAMY: Marriage to two or more persons of the opposite sex.

BILL: A formal declaration of particular things in writing. The word has diverse uses in law.

BLACKMAIL: To extort goods or money from another by the threat, in writing, of accusations or exposure.

BRIEF: A summary of the law relating to a case which is prepared by the attorneys for both parties to a case and handed to the judge.

BURGLARY: Breaking and entering another person's house with the intention of committing a felony therein.

CAPIAS: "That you take". The general name for writs that order the officer to arrest the defendant.

CAPITAL CRIME: Any crime punishable by death.

CAVEAT: A formal notice given to a judge or ministerial officer warning him not to perform contemplated acts within his jurisdiction.

CERTIORARI, WRIT OF: An order issued by a superior court directing an inferior court to send up to the former some or all the record of a case tried in the inferior court for review or trial.

CHAMPERTY: An agreement whereby a stranger to a suit agrees to finance one side in return for a share of the property that is secured through the action.

CHANCERY: see "equity".

CITATION: A writ, issued by the court, ordering a person to appear and perform a certain act.

COMPLAINT: One who sues another in a court of equity. Also one who initiates criminal prosecution.

CONTEMPT OF COURT: Behavior that impugns the authority of a court or obstructs the execution of court orders.

CONVEYANCE: Transfer of ownership in property. Also an instrument in writing which effects the transfer.

CORPUS DELICTI: The actual visible proof that a crime has been committed. Before murder can be proved in a court the corpus delecti, the murdered person must be found.

COVENANT: An agreement in writing by which someone pledges to someone else that something has been done or shall be done or that certain facts are true.

DECREE: The judgment of a court of equity or admiralty, answering for most purposes to the judgment of a court of Common Law.

DEED: A written instrument by which one person conveys land to another.

DEFENDANT: The person against whom relief or recovery is sought in an action.

DEMISE: A lease.

DEMUR: To raise an objection in point of law, and rest or pause upon it, referring its decision to the court.

DEMURRER: In court procedure a statement that the opposing party has no sufficient basis in law despite the truth of the facts advanced.

DEPOSITION: The testimony of a witness taken under oath, out of court, and reduced to writing for insertion into the record of the trial.

DEVISE: A gift of real property by will.

DISORDERLY CONDUCT: Minor offenses which tend to endanger public peace, safety of morals.

DISPOSSESS: (summary Proceeding). A legal process instituted by a landlord to regain possession of his own real property. The proceedings are short and simple in comparison with regular court action.

EMBEZZLEMENT: Fraudulent appropriation by a person acting in fiduciary capacity, of money entrusted by another.

EMBRACERY: The attempt to corruptly influence a juror.

EMINENT DOMAIN: The power of the state to take private property for public use.

EQUITY: A system of jurisprudence and tribunals, separate from the common law courts, the purpose of which is to render the administration of justice more complete by affording relief where the courts of law cannot give it.

ESTOPPEL: A legal prohibition which stops a man from making a particular statement because of something that he has said before.

ET AL: And others. Used after the names of plaintiffs, and defendants to indicate that other persons are involved besides those specially mentioned.

EX PARTE: Done by or for one side only and without notice to or contestation by any person adversely interested.

EXAMINATION: An investigation of a witness by counsel by means of questions for the purpose of bringing before the court the knowledg

EXCEPTION: A formal objection to the action of the court during a trial. The indication is that the excepting party will seek to reverse the court's action at some future proceeding.

EXECUTION AGAINST A PERSON: Such an execution may be obtained after judgment in the same actions in which orders of arrest are obtained. The debtor may be imprisoned for a period not exceeding six months, or until he pays the money. If the defendant serves the six months he may not be imprisoned again in the same action but he is not released of his debt.

EXECUTION AGAINST PROPERTY: After a judgment has been obtained, the attorney for the plaintiff issues an execution against the property. The execution means that the Marshall is ordered to carry out the judgment of the Court. Municipal Court Judgments must be executed by the City Marshall. All county and Supreme Court judgments are executed by the Sheriff. Some City Court judgments are executed by the Marshall, others by the Sheriff.

EXECUTIONS AGAINST WAGES: A "garnishee" execution is issued on any money judgment against "Wages, debts, earnings, salary, income from trust funds or profits which are or will be due the debtor to the amount of $12.00 a week".

EXECUTOR: The person named by a testator to carry out the provisions of his will.

EXTRADITION: Delivery from one state or nation to another of fugitives from justice.

FEE SIMPLE: Complete ownership of property with unconditional power of disposition during life.

FELONY: The term has no very definite or precise meaning, except in most cases it is defined by statute. Generally speaking, the legislatures of the several states declare whether or not an offense is a felony or not. Aside from this, the term usually connotates an offense or crime of a more serious nature than those designated as misdemeanors.

FIDUCIARY: Having the character of a trustee; invested with rights and powers to be exercised for the benefit of another person.

GRAND JURY: A jury of inquiry who are summoned and returned by an officer to each session of the criminal courts, and whose duty it is to receive complaints and accusations in criminal cases, hear the evidence adduced on the part of the state, and find bills of indictment in cases where they are satisfied that a trial ought to be held. They are first sworn and instructed by the court. This is called "grand jury" because it comprises a greater number of jurors than the ordinary trial jury, or "petit jury".

GUARDIAN AD LITEM: A guardian appointed to represent an infant in legal proceedings.

HOMICIDE: Killing of one human being by the act or omission of another human being.

INCHOATE: Imperfect; begun but not completed.

INDICTMENT: A written accusation by a grand jury charging a person with a crime for which he must be tried in court.

INFANT: One who is under twenty-one years of age.

INJUNCTION: An order by a court of equity prohibiting a defendant from committing an act which is injurious to the plaintiff.

INTESTACY PROCEEDINGS: See administration proceedings.

INTESTATE: A person who dies without having made a will.

IPSO FACTO: By the mere effect of an act or a fact.

JEOPARDY: The danger of conviction and punishment which a defendant in a criminal action incurs when a valid indictment has been found. Double jeopardy is prohibited under the constitution, that is, a man may not be tried twice for the same crime.

JUDGMENT: The official decision of a court of justice on the claims of parties to a litigation.

JUSTIFIABLE HOMICIDE: Homicide committed in pursuance of the law as when an executioner kills a criminal sentenced for first degree murder.

LACHES: Failure to assert a right for an unreasonable length of time under circumstances which are harmful to another person.

LARCENY: Unlawfully taking property belonging to another. Grand larceny is established when the property exceeds in value the amount set by statute. Petit Larceny is established by stealing anything less than this amount.

LETTERS TESTAMENTARY: The papers which give an executor the power to carry out the provisions of a will.

LEVY: When an execution is given over to a Marshall he must call upon the defendant, announce his position and his business and ask that the debtor pay the money involved. This is known as "making the levy".

LIBEL: Writing calculated to injure the reputation of another by bringing him into ridicule, hatred, or contempt. Slander is of the same nature except that it is verbal, not written.

LICENSE: A permission, accorded by competent authority, conferring the right to do some act without which such authorization would be illegal. In no sense can it be construed as a contract between the state and the person licensed.

LIEN ON CHATTEL, FORECLOSURE OF: In cases under municipal court jurisdiction, a lien is held by a seller on the installment plan until the buyer has paid the full purchase price. In an action to foreclose a lien, a warrant is issued commanding the Marshall to seize the chattel and keep it until judgment may be granted by the Court.

MANSLAUGHTER: The killing of another without malice.

MARSHALL: An officer of the courts empowered to carry out court orders. His duties are essentially those of the Sheriff. In New York City the Marshall and Sheriff work for different courts. See "Execution against Property".

MAYHEM: The act of wilfully depriving another of the use of one or more of his limbs so that he is less capable of defending himself.

MISDEMEANOR: An offense punishable by indictment which is not up to the grade of felony. Also offenses for which no punishment is provided.

MORTGAGE: A debt secured by a pledge of land or property.

NEGLIGENCE: That general class of civil suits arising from the defendants' failure to exercise reasonable care.

OBITER DICTUM: A remark made by a judge in his decision which does not bear directly upon the question before him.

ORDINANCE: A law or statute. In a more limited sense, the term is used to designate the enactments of the legislative body of a municipal corporation.

PANEL: A list of names required by competent authority to serve as jurors for the trial of a particular action.

PAROL: Oral or verbal; not expressed in writing.

PAROLE: A conditional release from prison.

PEREMPTORY CHALLENGE: The right of prisoner and the prosecution in a criminal trial to offer objection to a certain number of proposed jurors without giving any explanation.

PERJURY: The act of wilfully swearing falsely.

PETIT JURY: The ordinary jury of twelve men for the trial of a civil or criminal action.

PLAINTIFF: A person who brings a civil action against another.

PRIMA FACIE: So far as can be judged from the first appearance or at first sight.

PROBATE: The act and process of proving before a proper court, that a document is the valid and legal will of a testator.

PROBATION: The type of penalty whereby a convicted man is put under the jurisdiction of probation officers for a stated time instead of being sent to prison.

QUASI: Best defined as almost. It serves to distinguish between two or more approximately identical things. Thus:-a quasi-contract is "almost" a contract, yet not possessing the full character of a contract.

QUIT CLAIM: A release made out by one man certifying that he has no further cause for action against another man.

REFEREE:A person to whom a court action is referred to take testimony, hear the parties, and report thereon to the court.

RELEASE: The giving up of a right by the person to whom it belongs in favor of the person from whom it might have been demanded.

RELEVANT: Applying to the issue in question and consequently useful in determining the truth or falsity of an alleged fact.

REPLEVIN: Even though chattels rightfully belong to a man, he may not, by himself, take them from another who holds them wrongfully. By recourse to the particular action of replevin, he may cause the courts to order a Marshall to retrieve his chattels.

RES: A thing, an object: This word has a very wide use in law taking such forms as Rem, Re, Rerum. Res Judicta means a thing that has been judicially acted upon.

RES GESTAE: Things done; essential circumstances surrounding the subject; the circumstances, facts and declarations which grow out of the main facts and serve to clarify their character.

RESPONDENT: The party against whom a case is brought in a court of equity.

SEARCH WARRANT: A written order issued by the appropriate court for the search of a particular premises.

SUBPOENA: The process by which the attendance of a witness is required is called a subpoena.

SUBPOENA DUCES TECUM: A subpoena not only requiring the witness to testify, but also to compel him to bring all books, documents and papers that may have any bearing on the outcome of the proceedings.

SUBROGATION: Substitution of one person's claims, rights, or securities for those of another person.

SUI JURIS: Being fully able to manage one's own affairs.

SUMMONS: A writ given by legally constituted authority, requiring the authorized person to notify the person named that an action has been commenced against him in a court whence the writ issues, and that he is required to appear, on a day named, and answer the complaint in such an action.

THIRD PARTY PROCEEDINGS: The examination of a third party to find out whether any of the judgment debtor's property is in his posession.

TITLE: The written instrument or other means whereby a person's right to the ownership of property is established.

TITLE, ABSTRACT OF: A condensed history of the ownership of a piece of land, stating all the liens, charges, and liabilities to which it is subject. It is usually prepared for the benefit of a prospective purchaser.

TORT: A legal wrong committed against the person or property, for which reparation may be obtained by a suit at law.

TRUE BILL: An indictment handed down by a grand jury.

VENUE: The neighborhood, place or country in which an injury is declared to have been done, or fact declared to have happened.

VERIFICATION: Confirmation of the correctness or truth of a statement by a sworn statement to that effect.

WARRANT: A writ or precept from a competent authority to pursuance of law, directing the doing of an act, and addressed to an officer or person competent to do the act, and affording him protection from damage if he does it.

WRIT: An instrument in writing ordering a court officer to perform some specified duty.

TESTIFYING IN COURT

TAKING THE OATH

Comments: This is the formalized procedure of promising to hence tell the truth. It is routine but very solemn, hence is viewed with respect. The witness should face the clerk administering the oath, with the right hand upraised about head height.

When the clerk of the court completes administering the oath, the witness should state "I DO" in an audible and decisive manner. The oath must be taken in a serious and respectful manner. The witness should stand still and erect and listen to the oath, and he should not move or take a "traveling oath" on the way to the witness stand.

After taking the oath, the witness is invited to "take the stand". If the witness chair is on the opposite side of the courtroom from where the oath is administered, the witness should proceed directly there, but should not walk between the attorneys and the judge.

TAKING THE WITNESS STAND

Comments: This is the moment when all attention is directed toward the witness, which has a tendency to create a "stress" situation. Nervousness is to be expected, but some of the tension may be relieved by remembering that a witness is to relate only what he remembers or knows, and that the judge will protect him from undue harassment.

Witnesses are merely presenting facts for consideration and evaluation by the judge (or jury), hence any distracting anxieties, prejudices or favoritism should be repressed.

The witness should seat himself comfortably erect, without slouching, and with any appropriate notes or reports in his hand.

When asked, he should state his name and position (or address) in a clear manner, "I am John Williams of the Office of Special Investigation, Department of Social and Health Services, State of Washington."

Addressing the Questioner:

The judge is "Your Honor"
The attorneys are "Sir" or "Yes, Sir"/"No, Sir."
The accused is "Defendant" or "Defendant Jones."
A partner is "Investigator Smith."

Attitude on the Stand:

Comments: A professional impartial attitude should accompany the investigator to the stand.

A witness has a right to expect courtesy and respectfulness. In turn, it would seem that the same attitudes should be manifested by the witness.

Any display of animosity or hostility is easily detected and may influence the decision. Counsel for the defense is charged with the duty to protect the constitutional rights of his client. Although his tactics may assume a Jekyll-Hyde appearance, the defense attorney should not be regarded as the personal enemy of the witness.

Avoid showing prejudice against a defendant in court, even if it is justified. The pervert who committed an act of perversion upon a small child is still entitled to be judged by the jury and not prejudged by the investigator!

The purpose of a trial is to rebuild the facts of a criminal act so that the accused can be judged.

TECHNICAL LANGUAGE AND SLANG

Comments: Technical terms and slang are not always understood hence witnesses should use good English. A clear, firm "Yes, Sir" or "No, Sir" answer is generally desirable and convincing.

When asked "was he drunk", an answer "He was drunk" is more effective than he was "stinking drunk."

If a technical term or slang was mentioned the witness should explain what he meant by the term. Avoid slang, terms of exaggeration, flip answers, sarcasm or wisecracks.

RULES OF EVIDENCE

Comments: It is too late for an investigator on the stand to learn the simple rules of evidence. He must know these rules before he takes the stand or he may be subjected to embarrassment. The investigator should know that he must not give hearsay evidence, but testify to only things he has observed directly with his own senses. He must know that the law permits him to give hearsay evidence under certain exceptions to the hearsay rule, and these exceptions must be learned in a training school. He must not give opinions, or draw conclusions on the stand, because he is not permitted to usurp the function of the jury.

Testimony that this man was "reckless driving" is a violation of the rule of evidence against opinions or conclusions, or "I could see the burglar inside the filling station" will immediately classify an investigator as not knowing his business. An investigator must know that under an exception to the rule against opinions, he can give opinions on speed, sanity, drunkenness and reputation. And, of course, an expert qualified to the satisfaction of the court can give opinions.

CHANGING FROM EXAMINATION TO CROSS-EXAMINATION

Comments: When the witness stays on the stand for cross-examination it indicates he knows his business. If he seems anxious to leave, the defense attorney will say (in a loud voice), "Just a minute ________________, we have a right to cross-examine you!" This is calculated to infer to the jury that the witness is trying to get away and not tell all of the story -- that he may have something to hide which may be favorable to the defense.

Generally, a well-trained or experienced witness gets much better treatment on cross-examination than one who has neither training or experience. A good defense attorney often states "No questions", and does not cross-examine the witness who is very sure of himself. The attorney knows that further questioning of a skilled investigator witness may do even more damage to his client. This has been particularly true when the witness has been qualified as an expert witness on a particular subject.

The direct examination is usually very peaceful and routine. Immediately after the direct examination the defense attorney cross-examines the witness. The purpose of the cross-examination is to weaken and disprove the case of the prosecution: therefore, the witness can expect a searching cross-examination and testing of his knowledge of the case.

When the questioning shifts from direct examination to cross-examination the witness should not visibly brace himself for the anticipated onslaught.

Without realizing it themselves some veteran investigators are eager and positive in their testimony when questioned by the prosecuting attorney and without knowing it will assume a hostile and belligerent attitude towards "the enemy" in the form of the defense attorney. Needless to say, this change of attitude implies prejudice to a court and jury.

CREATING EMOTIONAL STRESS

Comments: Persons who are angry or emotionally upset may not think as clearly as when they are calm. It is upon this premise that some attorneys proceed to needle, coerce, intimidate, accuse, harass and belabor a witness to produce emotional stress. The objective is to disprove previous testimony, confuse the witness, and to discredit him in the eyes of the judge or jury.

Calmness, composure and courtesy toward an offensive attorney is the thing he wants least of all, and it is a sure way to turn the tables on him. Meeting the badgering type of cross-examination with dignity and courteous answers often begets a dislike by the judge and jury for the discourteous, offensive attorney.

This also requires the witness to know his case and be wary not to become tricked into making unsure statements. Some of these "trick" questions will follow.

AN OBJECTION IS MADE

Comments: Stop talking. Witnesses are responsible only for answers to questions asked. When an objective is made to a question, it then becomes the judge's prerogative to rule on the propriety of the question. The witness must wait for the ruling of the court on all objections before answering.

If the witness completes his answer and the judge then rules that the question is improper, both the question and the answer are stricken from the record. The stigma which would attach to the question would then seem to apply to the answer.

Following is a list of objections to the witness' testimony, which, if accurate, will be sustained by the judge:

1. Hearsay
2. Leading and suggestive
3. Asked and answered
   (sometimes "Cumulative", sometimes not)
4. Cumulative
5. No proper foundation
6. Argumentative
7. Irrelevant
8. Incompetent
9. Immaterial
10. Assuming fact not in evidence
11. Calling for a conclusion
12. Not the best evidence

13. Privileged communication
14. Beyond the scope
15. Self-incrimination
16. Opinion by non-expert
17. Impeachment of own witness
18. No corpus delecti
19. Unintelligible
20. Compound

TESTIFYING AS TO TIME, WEIGHTS, DISTANCES

Comments: Use approximations unless you have actually measured them.

AMBIGUOUS QUESTIONS

Comments: It is proper to ask for clarification. If the question is not clear, the witness should state, in a courteous manner, that the question is not clear to him, or that he does not understand what is meant. This sometimes gives the defense attorney an opportunity to state, "Now investigator, this is a simple question ----." He is not only belittling the witness, but he may also be downgrading the jury, some of whose members may also be wondering what was meant by the original question. Hence it would seem better procedure to ask for clarification than to guess at what was meant. If the question was subject to two interpretations, the witness may have answered in accordance with his own concept and the defense attorney then could argue that the answer was in response to the attorney's meaning of the question.

DOUBLE AND TRIPLE QUESTIONS

Comments: Answer each question separately.

ARGUMENTATIVE QUESTIONS

Comments: Answer calmly, courteously.

Q. "You Haven't been an investigator very long, have you?"

Comment: No explanation or apologies are necessary. Neither is it appropriate to make flip or caustic answers, such as, "I guess I know a drunk when I see one!"

Answer: "I have been an investigator for ____________."

Q. "Why are you here today?"

Comment: That is an attempt to elicit an answer such as, "To convict the defendant," which would show that the witness is a "volunteer" witness and anxious to convict.

The witness should state, "I am here by order of the court."

Q. "Did you advise the Defendant of his constitutional rights?"

Comment: This is not required in the State of Washington, but, if requested, the person arresting must inform the arrestee what he is being arrested for. It takes several years in law school to discuss a person's constitutional rights. If the situation was one where an incriminating statement was taken as the result of interrogation, the investigator will respond with a recitation of the admonition required by current general orders.

THE ANSWER "YES" OR "NO" PROBLEM

Comments: This is not a legal requirement.

Analyze question first. It is usually best to answer "Yes, sir", or "No, sir", or in as few words as possible. There are many questions that cannot be properly answered, "Yes", or "No", such as, "When did you stop beating your wife?" Answering yes or no admits that the witness is a wife beater.

But elaboration is possible if a shorter explanation will not answer the question.

It is quite proper for the witness to address himself to the judge by stating: "I cannot answer that question 'Yes' or 'No' -- may I have the court's permission to explain?" Do not make such a request to opposing counsel since this may appear to be argumentative or evasive. OR

Answer "Yes" or "No". The defense attorney may ask you a question and then say, "Answer yes or no." This is a favorite trick of the cross-examiner to try to force you to give a "yes" or "no" answer to a question, to prevent you from qualifying your answer. Many times such questions cannot be answered correctly that way. If an attempt to do so is made, the succeeding questions will proceed to show how the "yes" or "no" answer could not be true, and thus the witness becomes impeached.

This predicament can be avoided if the investigator will say, "I cannot answer the question correctly by either "yes" or "no" but I am willing to state the facts as I know them. The cross-examiner is then in the embarrassing position of apparently withholding the facts if he does not let the investigator answer in narrative form. However, if the question can be answered properly by "yes" or "no", a demand for such an answer may be reasonable. If the question is such that it cannot be answered fully by yes or no, the witness may ask the court if he must answer the question that way, explaining that neither would be the correct answer without further qualification. The court will probably say that the witness does not have to answer the question by "yes" or "no" because there is no rule of law requiring a "yes" or "no" answer. If he does require you to answer in that form, answer the question as best you can and let the prosecuting attorney bring out the full information later by questions on re-direct examination.

Q. Do you mean to say that. . . . etc.?

Comments: An attempt is being made to put a different interpretation on what you have just stated.

Q. "You're not sure are you?" or "You're not POSITIVE are you?"

Answer: "To the best of my recollection, that's the way it happened --- or that's what I observed, sir."

Q. As a matter of fact, Investigator, wasn't it this way. . . etc.?

Comments: This will be followed by a statement just the opposite of your testimony. Sometimes the seemingly friendly attorney will attempt some quasi-ingratiating prefix to a false statement, such as, "May I suggest to you that it happened this way. . .etc.?" Or another attempt to mislead the jury would be, "I submit to you that the real facts were. . .etc."

Q. "Did you enjoy watching (such and such events)?"

Comments: In sex and perversion cases the defense attorney may attempt to make the witness appear as a passive participant to the incident.

Answer: "No, I found it repulsive."

Q. "Why didn't you stop it?" (Referring to witnessing some lewd or perverted act.)

Comment: The investigative function in the judicial process is to secure sufficient evidence for presentation in court.

Answers: "The complaints I had were not for this act" . . . "I was watching for a felony to be committed." "I stopped it as soon as I could."

Q. Have you discussed the facts of this case with anyone?

Answer: "Yes, sir, with witnesses, my partner, the prosecuting attorney, my superiors."

Comments: The defense attorney may shout at the witness, "Whom have you talked to about this case, and who told you to testify the way you have?" This question catches witnesses every day. It is asked in an accusing manner. An answer may be: "I have talked with my supervisor, with other investigators, and with witnesses concerning this case, but no one has told me how to testify. I am here to tell the truth." It is really two questions in one: "To whom have you talked about this case?" and "Who told you to testify the way you have?" Sometimes the question is put in another form: "To whom have you talked about this case?" shouted at the witness in an accusing manner as if it were wrong to speak of it. The witness may get the idea from the accusing way in which the question is asked that "I've talked to a number of people, and all the time I should not have done so." This is an effort by the defense attorney to trick the witness into saying "NO" as if it were wrong to discuss the case with someone else.

If you answer that you have not talked this case over with the prosecuting attorney, you thus make it appear that you are lying. The best way to handle this question is to answer it by saying, "Yes, I discussed it with people," and name them. It is not wrong to discuss a case with the proper persons. That is what an investigator has to do to prepare his case and to get evidence. The cross-examiner knows that the prosecuting attorney would probably not use you as a witness unless you had talked the case over with him beforehand so that he would know what you can testify to.

If the defense attorney can trap a witness into telling a falsehood about a minor item, it tends to discredit all the testimony.

Q. "Didn't you and the prosecuting attorney get together and frame this whole thing?"

Comment: This is a typical shyster trick. Even with a complete denial, the implication is made to the jury that the witnesses are merely looking for a conviction. This is really two questions in one: 1. "Did you get together," and 2. "Did you frame the whole thing?"

The witness should discern this and give two answers:

Answers: "Sir you have asked me two questions. As to the first, we did meet to review this case from my original notes.

As to the second question, "did we frame this whole thing," we do not frame people -- we merely present facts for the judge and the jury to decide."

Q. "Didn't the prosecution tell you what to say?"

Answer: "He told me to tell exactly what happened."

Q. "Didn't he warn you about anything?"

Answer: "Yes, sir, he advised me to stick to the facts."

Q. "Have you rehearsed your testimony before coming to court?"

Answer: "No, sir, I have refreshed my memory by reviewing my notes."

Comments: It is a recommended procedure and the mark of a good investigator to come to court prepared to relate known facts. This demands an examination of pertinent notes, documents and physical evidence before court presentation in order to refresh your memory.

Q. "You stated you smelled alcohol on his breath. Just what is the odor of alcohol?"

Comments: Pure alcohol has no odor.

Answer: "I smelled odors associated with drinking alcoholic beverages. He had an odor like drunks I have arrested." Or, "He smelled like persons whom I have seen drinking alcoholic beverages."

Q. What does Opium smell like?

Answer: OPIUM (Nothing else smells like opium).

Q. "What does Marijuana smell like?"

Answer: MARIJUANA (nothing else smells like marijuana).

Q. "You don't like people who drink, do you?"

Comment: This would include over half the people in the world.

Answer: "I don't mind social drinking -- as long as it does not endanger or hurt people."

Q. "You want to see this defendant convicted, don't you?"

Comments: The cross-examiner may ask, "Do you want to see this defendant convicted?" By this question he is attempting to make you appear prejudiced in the eyes of the jury. Proof of an impartial, but fair attitude on the part of the witness may be shown when the question asked would call for an answer favorable to the defendant. The witness should not hesitate or be reluctant to mention facts favorable to the defendant.

Answers: "If he is proven guilty, he should be convicted," Or, "I am here to testify as to the facts as I know them, and the decision rests with the jury (or court).

Q. "Have you ever been drunk yourself?"

Comments: It is the duty of the prosecuting attorney to protect his witness from unfair questions. But most prosecutors are reluctant to interfere with the right of the defense to a complete cross-examination. This is why prosecutors are slow to defend their own witnesses. This question should be objected to on the basis that the officer is not on trial. If an attorney becomes so offensive and unfair that the investigator feels he is being abused, and the prosecuting attorney fails to object, then the investigator should assert his right to appeal to the court.

Answer: "Your honor, do I have to answer such a question?" (The duty then arises in the court to protect the witness from objectionable offensive or unfair questions.) If the question stands -- answer it.

Q. "What is your arrest quota every month?"

Answer: "We do not have a quota. I can only arrest when I have evidence of a law violation."

Q. "You dislike my client, don't you?"

Answer: "I feel sorry for any man in trouble."

Q. "You say you know this person well. Just tell me where he lives."

Comments: The witness should know.

Q. "Isn't it true you arrested this man because you were mad at him?"

Answer: "No, sir. I arrested him for breaking the law."

Q. "Now, investigator -- you have testified that .... etc."

Comments: This is often followed by a misquote of your previous testimony. It is quite possible that the witness did not testify exactly as the cross-examiner quotes, that the cross-examiner may be misquoting the testimony, and that the witness by this question is being led into a contradiction. Don't ever let a cross-examiner misquote you. Call it to his attention immediately if he does. You can do so by saying "Sir, I am sorry; I have not made myself clear to you. You seem to have misunderstood. The facts in my testimony are these. . ." Then repeat the true facts as you said them. By doing so, you bring the unfair tactics to the jury's attention, and, by repeating the true facts as you said them, you re-register them on the minds of the jurors. If you are stopped by the cross-examiner the case of the prosecution may be strengthened because the jury may believe that the cross-examiner is afraid to have you again state the facts correctly.

Q. "Why did you buy the defendant's wrist watch?"

Comments: Calculating criminals sometimes try to sell a real bargain to the investigator to weaken the case later. An investigator must not only avoid evil but must avoid the appearance of evil. Never become involved in "deals" or "bargains" with an arrested person.

Q. "What if I told you your partner said . . .?"

Comments: This type of question is usually a trap. The attorney does not say that you partner said anything.

Answers: "I didn't hear my partner's testimony. I can only tell you what I know myself." or

"I don't recall that he stated that." or

"I can only state what I saw (or heard) -- not what my partner saw."

Q. "Did your partner tell the truth, or are you telling the truth?"

Answer: "What I have told you is the truth, and I'm sure Investigator ________________ told you the truth to the best of his knowledge." or

"I can only relate the facts as I saw them. I'm sure investigator ________________ did the same."

Q. Doesn't your testimony (or statement) conflict with that has been testified to here in court?"

Answer: "To the best of my ability I'm relating what I observed and recall."

Comments: Investigators are sometimes concerned that the testimony of each investigator will not correspond with that of every other investigator. Wide differences between the testimony of different witnesses would perhaps minimize the credit to be given to such testimony; but if testimony which from its nature is open to different explanations is too much the same, the danger is equally great. Each officer should not try to state the facts which he knows in the identical way that every other investigator does. Whether the evidence of each investigator be alike or different, defense counsel is sure to criticize. If too identical, he can claim proof of error. Therefore, if the investigator keeps his mind on what the facts are as he knows them, without trying to be consistent with the statement of every other witness, he will avoid confusion.

Q. "You weren't too sure about this case a few days ago, were you."

Comments: The cross-examiner may ask accusingly, "When you were called as a witness in this case isn't it true you said to someone, 'I don't remember much about it,' and yet today in the courtroom you tell your story in detail. How do you explain that?" It is possible that you did say something like that, but you can state that you have gone through the process known as "refreshing recollection". Perhaps you revisited the scene of the crime, looked into your notebook to recall dates, or discussed the incident with other witnesses, all of which is perfectly proper. In fact, it is about the only way in which witnesses can recall details and make sure they are telling the truth.

Answer: "That's right, but since then I've reviewed my notes, read the confession, etc."

UNANSWERABLE QUESTION

Answers: "I can't answer that." "I don't know."

MAKING A MISTAKE

Comment: Correct it immediately, or as soon as remembered. An honest correction impresses the court and jury of the truthfulness of the witness.

Answer: "I have made a mistake, and I would like to correct it now. I do not remember whether it was raining at the time the accident was investigated."

APPENDIX B - LEGAL DEFINITIONS

Q. "You say you believe so-and-so; we are not interested in what you believe. We want you to relate what you know to be a fact."

Comments: Give no opinions or conclusions unless asked for them. These are usually when the witness qualifies as an expert witness or as an exception to the hearsay rule.

Q. "Have you read (or heard on the radio, or seen on TV) anything about this case?"

Comments: There is no law against learning about a case. Nor is it improper.

Hence, "Yes, sir, I read (heard or saw) about it in the newspapers," would be proper.

ON COMPLETION OF TESTIFYING

Comments: After you have finished testifying, leave the courtroom unless you have been retained by the court or by counsel. Staying in the courtroom after the work of testifying is over and visiting with the other investigators creates the impression that you are over-zealous and perhaps too much concerned with the outcome of the case.

It is permissible to respectfully ask the court, "Your honor, may I be excused?" If permission is granted, the witness may leave. If permission is not granted, he must remain in or near the courtroom until officially excused.

A witness who has been cross-examined should not try to testify to anything he may have forgotten. However, after leaving the stand it is possible to jot down on a piece of paper what was omitted and hand it to the prosecuting attorney. It is his job to evaluate evidence and he will request the judge to recall the witness if he deems it appropriate.

SEE ATTACHMENTS

BRIEF REVIEW OF COMMON TACTICS OF CROSS EXAMINATION

Counsel's Tactic	Example	Purpose	Investigator's Response
Rapid fire questions	One question after another with little time to answer.	To confuse the witness; an attempt to force inconsistent answers.	Take time to consider the question; be deliberate in answering, ask to have the question repeated, remain calm.
Condescending counsel	Benevolent in his approach, over-sympathetic in his questions to the point of ridicule.	To give the impression that the witness is inept, lacks confidence or may not be a reliable witness.	Firm decisive answers asking for the question to be repeated if improperly phrased.
Friendly counsel	Very courteous, polite; questions tend to take witness into his confidence.	To lull the witness into a false sense of security where he will give answers in favor of defense.	Stay alert; bearing in mind that purpose of defense is to discredit or diminish the effect of your testimony.
Badgering, belligerent	Counsel staring you right in the face, shouts "That is so, isn't it, investigator.	To make the witness angry so that he loses his sense of logic and calmness. Generally, rapid questions will also be included in this approach.	Stay calm, speak in a deliberate voice, giving prosecutor time to make appropriate objections.
Mispronouncing investigator's name; using wrong rank	Investigator's name is Jansen, counsel calls him Johnson.	To draw the witness's attention to the error in pronunciation rather than enabling him to concentrate on the question asked so that the witness will make inadvertent errors in testimony.	Ignore the mispronouncement and concentrate on the question counsel is asking.

Counsel's Tactic	Example	Purpose	Investigator's Response
Suggestive question (tends to be a leading question allowable on cross-examination)	Was the color of the car blue?	To suggest an answer to his question in an attempt to confuse or to lead the witness.	Concentrate carefully on the facts, disregard the suggestion. Answer question.
Demanding a "yes" or "no" answer to a question that needs explanation	Did you strike the defendant with your club?	To prevent all pertinent and mitigating details from being considered by the jury.	Explain the answer to the question; if stopped by counsel demanding a "yes" or "no" answer, pause, until the court instructs you to answer in your own words.
Reversing witness's words	Witness answers, "The accident occurred 27 feet from the intersection." Counsel said, "You say the accident occurred 72 feet from the intersection?"	To confuse the witness and demonstrate a lack of confidence in the witness.	Listen intently whenever counsel repeats back something you have said, if he makes an error, correct him.
Repetitious questions	The same question asked several times slightly rephrased.	To obtain inconsistent or conflicting answers from the witness.	Listen carefully to the question and state, "I have just answered that question."
Conflicting answers	But, Investigator Smith, Investigator Brown just said, etc.	To show inconsistency in the investigation. This tactic is normally used on measurements, times, etc.	Remain calm, conflicting statements have a tendency to make a witness extremely nervous. Be garded in your answers on measurements, times, etc. Unless you have exact knowledge, use the term "approximately". Refer to your notes.
Staring	After the witness has answered, counsel just stares as though there were more to come.	To have a long pause that one normally feels must be filled thus saying more than necessary. To provoke the witness into offering more than the question called for.	Wait for the next question.

FILE SYSTEM

I. PURPOSE

The purpose of this procedure is to provide a basic outline for the establishment of an S.I.S. file system in the Area Field Offices. The user should examine the structure of the file and apply the basic principle of filing by subject to his correspondence and reports.

The file is divided into two parts: Reports and correspondence. By separating the reports from the correspondence, the user can file and find the reports very quickly. It is hoped that this file organization will provide the user with better control over office activities.

II. SCOPE

This procedure applies to current correspondence and reports. If frequently used, earlier correspondence and reports can be kept in a file folder behind the current or transferred to the current file folders.

III. DEFINITIONS

A. Reports will have the following characteristics:

1. The title will show the word "Report".
2. The record will list figures, statistics, data, etc.
3. Most report information is entered on a numbered form.
4. The reports may be addressed to the Field Office Supervisor, Special Investigative Section (S.I.S.) or the Director, S.I.S.
5. Reports usually do not require action on the part of the receiver.

B. Correspondence includes memos, letters, forms, pamphlets, etc. affecting the administration of the Area Field Office:

The following is a definition of the six correspondence sections of the file:

200 Administrative Correspondence

This correspondence affects all S.I.S. policies and procedures in general and the maintenance of the office.

300 Service Correspondence

This correspondence affects specific types of investigations; e.g., personnel investigations, special investigations, food stamp investigations, etc.

400 Personal Correspondence

This correspondence affects individual S.I.S. staff of the office. Also general information on personnel matters affecting staff would be filed in this section.

500 Meeting Correspondence

This would include correspondence to and from community organizations, records of meetings attended by local office staff, etc. This category differs from category 600 in that a staff member is in attendance at the meeting.

Minutes of Area Field Office meetings would be included.

600 Service Organization Correspondence

This would include correspondence sent to and received from cooperating state and federal agencies providing service to S.I.S. This correspondence would notify the Area Field Office of cooperating agencies and any other individuals or organizations that could be useful as collateral contacts.

700 Publications

This would include all bulletins, brochures, booklets, etc. received in the Area Field Office.

IV. PROCEDURE

A. Identify whether the record is a report or correspondence.

B. Identify the subject. Check the record for:

   1. Person's name

   2. Organization name

   3. Publication

   4. Any other key word which indicates the subject being discussed.

C. Follow the filing procedure as outlined in this package.

OUTLINE FOR THE UNIFIED FILE SYSTEM

100 REPORTS

110 S.I.S. Log DSHS 2-177

111 Weekly Activity Report

112 Fraud Statistical Summaries

113 Administrative

114

115

116

120

121 Travel & Per Diem

122

130 Personnel

131 Training

132 Attendance

200 CORRESPONDENCE

200 Administrative Correspondence

210 Complaints

220 Policy Exceptions

230 Fair Hearings

240 Office Policy

250 Office Operation

260 Speeches

270 Legislation

300 INVESTIGATIVE CORRESPONDENCE

310 Staff Personnel Investigations

Filing System

320 Special Investigations
330 Lost and/or Stolen Warrant Investigations
340 Food Stamp Investigations
350 Out of State Investigations

400 Personnel Correspondence

410 Administrative Staff
420 Consultants
430 Area Field Office Staff
440 Positions
450 Training

500 Meetings

510 Area Field Office
520 Statewide Section
530 Training
540 Professional Organizations

600 Social Security Administration
610 Veterans Administration
620 U. S. Postal Service
630 Law Enforcement Agencies
640 Labor & Industries
650 Employment Security
660
670

700 Publications

Filing System

710 Newspapers

720 Bulletins-Pamphlets

730 Books-Catalogs

Outline for Installation

To establish an Area Field Office file:

1. Type a list of the file folder topics, headings & sub-headings.
2. Type labels for the folders and guides; prepare the folders.
3. Type the alphabetic card index. Use the topic list of subjects for reference. Type one card for each subject.
4. Place the guides and file folders in the file.
5. Transfer the frequently used current correspondence and reports to the new file folders.

Notebook Binder Files

D.S.H.S. Manuals

Numbered Memos

General Recommendations:

1. Use different colored labels for each of the seven divisions of the file.
2. Put cross reference information on the alphabetic index cards.
3. Receiver of the records indicates in the upper left hand corner how long it should be kept in the active files and whether or not after that period it should be transferred or destroyed.
4. Use card files to accumulate much used information such as meetings, phone numbers, nursing homes, day care homes, etc.
5. Use a charge out card for follow up register for records that will be taken from the files for a long period of time before being returned.

Alphabetic Card Index

Type an index card for each subject in the file. This card should contain:

1. The number assigned to the subject in the upper left hand corner.
2. The subject of the correspondence filed in the folder.

3. Any action taken or required to be taken on that particular subject.

4. Any cross reference information, for example, a reference to another subject in the file where more information can be obtained on the subject.

Filing Procedure

Steps in the filing of correspondence and reports:

1. Inspecting

   Check the correspondence and reports to make sure they have been released for filing.

2. Alphabetic Indexing & Coding

   Underline the name or subject under which the paper is to be filed. If the subject is not covered in the file, you can put the paper in a miscellaneous folder such as, 210 Complaints, 310 Special Investigations, 350 Out of State Investigations, etc. When five or more pieces have been stored up on one subject in the miscellaneous folder establish a new file folder for that subject. On most papers you will be able to find a subject in the file which will be appropriate.

3. Alphabetic Sorting

   Papers should be arranged alphabetically according to the coded names or subject to expedite the use of the card index. Sort first by the main heading. Then these piles should be further sorted according to the divisions of the main heading and then by the sub-division. For example, Administrative Correspondence--Complaints.

4. Numeric Coding

   Write the file number found in the card index in the upper right hand corner of each paper.

5. Numeric Sorting

   Each paper should be placed in numeric sequence.

6. Storing

   Papers should be stored in the subject-numeric file. The records for each folder should be arranged chronologically with the latest date in front.

Numbered and Un-Numbered Memos

The subjects of the numbered and un-numbered memos could be incorporated into the alphabetic card index. This would require the classifying of each memo by the key words in the subject. For example, Memo #69-17 issued January 31, 1969 would be classified Food Stamps--Reduced Price School Lunches for Children from Families Eligible For. The classification would then be entered on the appropriate index card.

Filing System

MAIN DIVISION	SUB-DIVISION	FOLDERS
100 Reports		
	110 S.I.S. Log DSHS 2-177	
		111 Fraud Activity
		111.1 Cases Referred to Prosecutor
		111.2
		112
200 Correspondence		
	200 Administrative Correspondence	
		201 Standard Operating Procedures, S.I.S.
		201.1 Area Office Procedures
		201.2
300 Service Correspondence		
	310 Staff Personnel Investigations	
		310.1 Employee Misconduct
		310.2 WATS-SCAN Investigations
		310.3 Food Stamp Fraud
		310.4

Exhibit O

CHRONOLOGICAL RECORD OF MEDICAID FRAUD AND ABUSE CASES INVESTIGATED

By: Department of Social & Health Services
Office of Investigation, Olympia, Wa.
Robert E. Neilson, Director (206) 753-6599

DATE OF OPENING	NAME OF VENDOR	NATURE OF ALLEGATION	RESULTS AND DISPOSITION
2-11-74	Nursing Home Vancouver	Misuse of patients' funds	"Honest mistake, misunderstanding, etc. Couldn't prove fraud. Home reimbursed DSHS $17,000 for proper distribution to patient trust accounts.
5-10-74	Nursing Home Ephrata	Diversion of patient funds for personal use of administrator	Case referred to Grant County Prosecutor. Administrator paid OSI investigator $6,000 cashiers check which DSHS distributed to proper accounts. DSHS moved patients out of home and nursing home closed its operation.
5-18-74	Convalescent Center Midway	Nursing home auditor misappropriated $6,000	King County Prosecutor refused to prosecute after auditor returned $6,000 to nursing-home account.
6-19-74	Pharmacy Seattle	Refused to accept return of unused drugs from doctor of welfare patient who died.	No fraud found. Recovery made of $600 for unused drugs.
8-22-74	Nursing Home Colville	Illegal charges to patients and misuse of patients' trust funds	Fraud found but not prosecutable (witness problems). Restitution of $771 obtained and facility advised of frequent, unscheduled audits.
9-12-74	Ambulance Co. Everett	Improper and illegal billings to DSHS for services not rendered.	Unable to substantiate allegation. Case closed.
-13-74	Chiropractor Everett	Chiropractor billed DSHS for treatments not performed.	Snohomish County Prosecutor refused to charge - too small amount. OSI took case to Discipline Board, State Chiropractor's Assoc. who caused suspension of subject's license.
-17-74	Dentist Mt. Vernon	Charging welfare patients for broken dental appointments	No fraud. Misunderstanding. Doctor reimbursed patient $4 and agreed to follow DSHS procedures.
2-16-74	Nursing Home Spokane	Charging DSHS at skilled nursing rates for actual intermediate care service	Fraud not determined. Lack of witnesses. DSHS was reimbursed $1,187.
2-20-74	Pharmaceutical Firm Twin Falls	Falsification of billings to DSHS (Spokane and Seattle)	Two charges - King and Spokane County. Prosecution still under consideration but dispute as to jurisdiction. Firm had contract cancelled by DSHS and moved out of state 4/75.
1-13-75	Ambulance Co. Seattle	False billings to DSHS for services not actually rendered, altering trip tickets to qualify for DSHS payment	King County Superior Court found vice president guilty of four counts of petty larceny. Fines totalling $8,000 ordered, 30 days in jail and restitution of $266,000 to DSHS ordered.
3-07-75	Parent Nursing Home corp. Bellingham	Falsifying cost factors to increase cost reimbursement by DSHS	Villa Care, Inc. (owner of Bellingham Villa and five others) under audit and King County Prosecutor advising OSI. Two sets of accounting books discovered.
2-14-75	Doctor Everett	Requiring patients to take prescription to his "preferred" pharmacy	Allegation false. Doctor didn't own pharmacy and was and is sending prescriptions to man drug stores.
2-14-75	Congregate Care Seattle	Billing DSHS for patients not in facility.	King County Superior Court sentenced one owner to 15 years, suspended. 60 days in jail; ordered restitution of $9,097. Second owner exonerated as result of polygraph test.

DATE OF OPENING	NAME OF VENDOR	NATURE OF ALLEGATION	RESULTS AND DISPOSITION
2-24-75	Day Care Center Seattle	False billing to DSHS as to the number of children in center	Couldn't prove fraud. Overpayment of $500 established and center is challenging via Fair Hearing as to fairness of DSHS rules.
3-10-75	Nursing Home Bellingham	1. Misuse of patients' trust funds 2. Assault (death) of patient	Allegation #1: Proved and nursing-home license and license of operator revoked Allegation #2: Turned over to Whatcom County Prosecutor who has never filed
4-15-75	Parent Corporation of 4 nursing homes. Seattle	Embezzlement of patient trust funds by operator	Case taken to King County Prosecutor. West Care, Inc. (owner of 4 other nursing homes) now defunct and all nursing homes formerly in corporation operating as congregate care facilities.
4-18-75	Nursing & Convalescent home Walla Walla	Improper billing to patient's trust funds for supplies/services which DSHS would have paid	OSI awaiting final audit - prosecution possible
4-21-75	Memorial Park & funeral home Seattle	Improper billing to DSHS, resulting in overpayment	Proved to be L.O. clerical error and no overpayment and no fraud
5-06-75	Parent Corporation of 6 nursing homes. Seattle	Embezzlement of patient trust funds	Pled guilty in King County Superior Court 2-19-76 and fined $10,000. Included in allega tions were six other nursing homes owned by Royal Care
5-28-75	Pharmacy Mt. Vernon	Billing DSHS for drugs which VA would have provided free	L.O. error in advising firm-practice was o.k. non-fraud
7-02-75	Juveniles-runaway receiving home Spokane	Each of three juvenile-runaways-receiving homes false billing DSHS for services not rendered	Awaiting prosecution, Spokane County. Overpayment at about $220,000
7-07-75	Convalescent Center Spokane	Misuse and misallocation of patient trust funds	Assigned to OSI in error. Investigation revealed an audit problem
7-18-75	Medical Center Brewster	Double billing by hospital (DSHS and recipient)	Finding of no irregularity. Recipient had services rendered that were not reimbursable by DSHS. Recipient liable for payment and no overpayment exists
8-04-75	Convalescent Center Elma	Bad working conditions Bad patient care	No criminal act discovered. Office of Nursing Home Affairs, DSHS, notified of our investigation for follow-up inspections
8-05-75	Nursing home Chehalis	Use of patient trust funds without written permission	No fraud. Home reimbursed patients' trust fund $400
8-12-75	Physician Seattle	Duplicate narcotic prescriptions to patients	OSI unable to prove fraud. Because of ethical ramifications, case turned over to Washin ton State Pharmaceutical Board
8-14-75	Day Care Center Seattle	False billing as to number of children in center	Fraud not provable and OSI returned allegation to local office for administrative actio

DATE OF OPENING	NAME OF VENDOR	NATURE OF ALLEGATION	RESULTS AND DISPOSITION
8-15-75	Ambulance Co. Yakima	Double billing to DSHS	Unproven and case closed. No action needed or taken
8-21-75	Nursing Home Seattle	Embezzlement of patient trust funds	Fraud not provable. Administrative action recommended. (Nursing home terminated their operation 11/75)
8-26-75	Nursing Home Camas	Co-mingling of patient trust funds with home's operating funds	Fraud not provable. Restitution of funds to patients' trust fund ordered after audit determines amount. Home ear-marked for continuing audit.
8-29-75	Parent Corporation - 8 nursing homes Bellevue	Owner of this 8 nursing home corp. committing forgery and/or embezzlement of trust fund	Case referred for prosecution and currently under investigation and audit
9-02-75	Congregate Care Seattle	Embezzlement of patient trust funds	False allegation. Case closed. No action needed or taken
9-18-75	Doctor Spokane	Doctor required recipient to pay $10 initial care fee	No abuse or fraud involved. DSHS procedures were followed by doctor
10-14-75	Drug Company Yakima	Double billing to DSHS	Investigation resulted in referral to Yakima County Prosecutor. Prosecutor still has case. No overpayment involved - attempt only
10-17-75	Nursing Home Spokane	Incorrect and illegal fee charges to DSHS	Referred to Spokane County Prosecutor. Restitution of $779 effected. (see 12-16-74 entry)
10-20-75	Nursing Home Seattle	Assault on patient	Case referred to OSI by Office of Nursing Home Affairs. After they found "no evidenc case closed - insufficient evidence
10-23-75	Day Care Yakima	Charging DSHS for services not rendered	OSI referred case to U.S. Attorney. On 1/12/76, U.S. Attorney accepted a schedule for repayment of $1,152 in lieu of prosecution due to age of owner (67)
10-23-75	Medical Center Monroe	Forgery of welfare checks by employee of center	Referred to Monroe Police. not an OSI case
12-02-75	Day Care Seattle	False billing to DSHS as to number of children in center	Allegations verified sufficient to refer to King County Prosecutor. Awaiting results as of 2-25-76
12-05-75	Rest Home Wenatchee	Patient assaulted and died	Case turned over to county sheriff. Prosecution declined - assaulter eighty-two-year old.
12-11-75	Optical Co. Spokane	Firm inducing recipients to purchase (through friend or relative) expansive frames not authorized	No fraud provable. Firm advised to monitor and educate staff to cease and desist.

DATE OF OPENING	NAME OF VENDOR	NATURE OF ALLEGATION	RESULTS AND DISPOSITION
2-12-75	Drug Store Ellensburg	Dispensing drugs to recipients and billing DSHS with no prescription from physician.	Case referred to Kittitas County Prosecutor and Washington Pharmaceutical Board
2-30-75	Drug Store Seattle	False billing to DSHS for prescriptions and other illegal acts.	OSI and Narcotic Squad, Seattle Police, and DSHS currently coordinating investigation with King County Prosecutor for criminal charges
12-31-75	Extended Care Center Battleground	Misappropriation of patient trust funds.	After investigation, OSI referred case to Office of Nursing Home Affairs, DSHS, when fraud was determined difficult to prove. Restitution promised by firm.
-04-76	Psychiatrist Seattle	False billings for services not rendered.	Currently under investigation as of 2-25-76
-02-76	Convalescent Center Wapato	Misuse of patient trust funds	Currently under investigation as of 2-25-76
-09-76	Nursing Home Spokane	Nursing home charging DSHS for patient not in home	Determination of "clerical error" made by OSI, DSHS reimbursed $233
-20-76	Nursing Home Olympia	Patient mistreatment and drug trafficking	Currently under investigation as of 3-08-76
-04-76	Nursing Home Vancouver	Misuse of patient trust funds	Currently under investigation as of 3-08-76
-08-76	Nursing home corporation Seattle	Embezzlement of patient trust funds (nine separate homes)	Currently under investigation as of 3-08-76

EXHIBIT P

DEFINITION OF FRAUD:

Federal regulations (45 C 250.80 (1)) states that "the definition of fraud for purposes of this section will be determined in accordance with state law. Although fraud may be defined in many ways the state statute used most often in prosecuting cases of medical vendor fraud is the larceny statute RCW 9.54.010, which reads as follows:

> LARCENY. Every person who, with intent to deprive or defraud the owner thereof --
>
> (1) Shall take, lead or drive away the property of another; or
>
> (2) Shall obtain from the owner or another the possession of or title to any property, real or personal, by color or aid of any order for the payment or delivery of property or money or any check or draft, knowing that the maker or drawer of such order, check or draft was not authorized or entitled to make or draw the same, or by color or aid of any fraudulent or false representation, personation or pretense or by any false token or writing or by any trick, device, bunco game or fortune-telling; or
>
> (3) Having any property in his possession, custody or control, as bailee, factor, pledgee, servant, attorney, agent, employee, trustee, executor, administrator, guardian or officer of any person, estate, association or corporation, or as a public officer, or a person authorized by agreement or by competent authority to take or hold such possession, custody or control, or as a finder thereof, shall secrete, withhold or appropriate the same to his own use or to the use of any person other than the true owner or person entitled thereto; or
>
> (4) Having received any property by reason of a mistake, shall with knowledge of such mistake secrete, withhold or appropriate the same to his own use or to the use of any person other than the true owner or person entitled thereto; and
>
> (5) Every person who, knowing the same to have been so appropriated, shall bring into this state, or buy, sell, receive or aid in concealing or withholding any property wrongfully appropriated, whether within or outside of this state, in such manner as to constitute larceny under the provisions of this chapter -- Steals such property and shall be guilty of larceny.

Robert E. Neilson, Director
Office of Special Investigation
State of Washington, Department
of Social and Health Services

EXHIBIT Q

EMPLOYEE MISCONDUCT INVESTIGATIONS

Beginning 1 August 1973

EMPLOYEE, ELD OFFICE & NVESTIGATOR	DATE INVESTIGATION COMPLETED	NATURE OF ALLEGATION	$ AMOUNT OF LOSS IF APPLICABLE	DISPOSITION
) I.I.E. (M) Vancouver Hines	8-13-73	Forgery of recipient check	NA	Allegation unfounded
) E.S. (M) Vancouver Hines	8-14-73	Falsified form in order to receive duplicate paycheck	$105	Bank to recover. Prosecution refused
) G.G. (M) Vancouver Hines	8-17-73	Employee living with A/R. A/R failed to reveal income - collusion	NA	Reprimand - both supervisor and employee. Employee discharged.
) J.W.S. (M) Everett New	8-24-73	Altered ATP card and kept FS	$20	Confessed - resigned
5) T.J.R. (M) Vancouver Kingston	8-24-73	Sexual advances to A/Rs	NA	Referred to administrator for disciplinary action
6) P.K. (F) Yakima Weaver	9-12-73	Aiding and abetting A/R to receive illegal amounts of FS	$310	Employee terminated. Later re-hired with reduction in grade and pay
7) M.D. (F) Vancouver Ronan	10-3-73	Food stamp deception	NA	Unfounded
8) B.R. (M) State Off. Gwynne	10-4-73	Misuse of State property	NA	Allegation unfounded

EMPLOYEE MISCONDUCT INVESTIGATIONS

Beginning 1 August 1973

EMPLOYEE FIELD OFFICE & INVESTIGATOR	DATE INVESTIGATION COMPLETED	NATURE OF ALLEGATION	$ AMOUNT OF LOSS IF APPLICABLE	DISPOSITION
9) C.B. (F) Seattle Templeton	10-23-73	EMPLOYEE - RECIPIENT. Failed to report change of circumstances.	$180	Proved. Mandatory overpayment and administrative discipline
10) R.S. (M) Yakima Weaver	11-1-73	Living with A/R.	NA	Letter of reprimand. He married and is no longer a State employee.
11) J.S. (M) Vancouver Ronan	12-18-73	EMPLOYEE - RECIPIENT. Failure to report outside income.	$392	Restitution ordered by administrator
12) D.P. (M) Seattle Gibson	12-28-73	Employee accused of assisting in welfare recipient fraud for sexual purposes.	NA	Employee discharged
13) D.B. (M) Spokane Schaller	2-22-74	Improper sexual relationship with A/R	NA	Unprovable. Still employed.
14) M.B. (F) Vancouver Ronan	3-27-74	Collusion with A/R to receive illegal welfare funds	NA	Unfounded. No disciplinary action.
15) W.S. Hospital State Off. Hines	4-1-74	Pilferage by unknown state employees	NA	Could not verify
16) W.W. (F) Seattle Hines	4-17-74	Mail clerk misappropriated welfare checks by forgery.	$605	Convicted - U.S. District Court. Two years in Federal prison in conjunction with Federal charge.

EMPLOYEE MISCONDUCT INVESTIGATIONS

Beginning 1 August 1973

EMPLOYEE, IELD OFFICE & INVESTIGATOI	DATE INVESTIGATION COMPLETED	NATURE OF ALLEGATION	$ AMOUNT OF LOSS IF APPLICABLE	DISPOSITION
.7) I.L. (F) Yakima Weaver	7-11-74	Assisting illegal alien in obtaining welfare funds.	$66	Non-provable. (Still under investigation for possible "ring" activity and conspiracy, working with U.S. Immigration.)
18) C.R. (F) Seattle Gibson	7-31-74	Falsifying employment records	$1,089	Convicted in Superior Court - 3 years deferred sentence, restitution, 500 hours community service work.
19) O.A. (F) Tacoma Buck	8-15-74	Forgery of recipient check.	NA	Allegation unfounded.
20) W.Y. (M) Seattle Gwynne	9-13-74	Misuse of State employee time -- Had typist doing non-job oriented work.	NA	Resigned.
21) H.T. (M) Seattle Gibson	10-8-74	Living with A/R - False information to increase benefits.	NA	Unable to substantiate. Employee terminated.
22) W.M. (M) Tacoma Hubert	10-14-75	Illicit association with parolee	NA	Administrative action. Employee discharged.
23) D.E.W. (M) Tacoma Engelhart	10-15-74	Theft from institution PX.	$7,200	Referred to prosecutor. Employee in nursing home and extradition problems with principal witness. No action taken
24) L.M. (F) Seattle Roscoe	10-16-74	Theft of office supplies from Fircrest Sanitarium.	NA	Unable to substantiate. Returned to City Police.

EMPLOYEE MISCONDUCT INVESTIGATIONS

Beginning 1 August 1973

EMPLOYEE FIELD OFFICE & INVESTIGATOR	DATE INVESTIGATION COMPLETED	NATURE OF ALLEGATION	$ AMOUNT OF LOSS, IF APPLICABLE	DISPOSITION
25) A.H. (F) Seattle Hobson	10-23-74	EMPLOYEE - RECIPIENT. Unreported income and false child care receipt.	$4,411	Convicted in Superior Court - Restitution, 3 year deferred sentence.
26) L.M. (M) Seattle Arnett	10-25-74	Illegal trafficking in FS sales	NA	Non-provable.
27) B.P. (F) Seattle Roscoe	10-31-74	EMPLOYEE - RECIPIENT. Falsified living conditions.	NA	Unfounded. Occurred prior to employment.
28) D.B. (M) Yakima Weaver	11-1-74	Misuse of State funds.	$287.96	No criminal charge. Reduction in grade and pay.
29) W.S.P. State Off Templeton	11-13-74	Misuse of prisoner trust funds.	$2,800	Unfounded. Bookkeeping procedure incorrect. No illegal activity.
30) K.M.R. (F) Vancouver Ronan	11-30-74	Collusion with A/R - A/R not required to report income.	$320	Unfounded. Employee completely exonerated.
31) L.W. (F) Yakima Gauthier	12-2-74	Forged State documents and checks.	$350	Document examiner could not prove. Bank collected. No loss to State.
32) F.S. (F) Seattle Gwynne	12-17-74	EMPLOYEE - RECIPIENT. False information on grant application.	$200	Unable to prove. Administrative action - restitution ordered as condition of continued employment.

EMPLOYEE MISCONDUCT INVESTIGATIONS

Beginning 1 August 1973

EMPLOYEE IELD OFFICE & INVESTIGATOR	DATE INVESTIGATION COMPLETED	NATURE OF ALLEGATION	$ AMOUNT OF LOSS, IF APPLICABLE	DISPOSITION
3) A.H. (F) Seattle Hobson	1-13-75	EMPLOYEE - RECIPIENT. Unreported income.	$264.17	Non-fraud. Overpayment arranged.
34) J.R. (F) Seattle Gibson	1-13-75	Collusion with A/R to receive illegal welfare funds.	NA	Inconclusive evidence.
5) D.U. (M) Olympia Tucker	1-14-75	Misuse of job position to extend privilege to realtors. Purchase of real estate from A/R.	NA	Allegation could not be proved. Employee resigned.
36) P.T. (F) Vancouver Ronan	1-27-75	Irregularity in handling pupil fund at school for the blind.	$567	Case at Prosecutor's. Employee dismissed. No action by prosecutor as of 7-9-76.
37) R.S. (M) Yakima Gauthier	2-18-75	Illicit sexual relations with retarded child.	NA	Resigned and case sent to Prosecutor's. Prosecution refused - lack of witness coordination of testimony.
38) S.T. (F) Everett Hines	3-17-75	EMPLOYEE - RECIPIENT. Unwarranted disclosure of office records to A/R and failure to report income (child support).	$1,028	Convicted - 3 year deferred sentence, restitution of $493 ordered by court.
39) W.W.L.O. Yakima Weaver	3-19-75	Food Stamp theft.	$132	Apparent mishandling of Food Stamps - could not prove.
40) J.R.W. (F) Seattle Gibson	4-7-75	EMPLOYEE - RECIPIENT. Failure to report retirement refund.	$797	Occurred between employment. Overpayment arranged.

EMPLOYEE MISCONDUCT INVESTIGATIONS

Beginning 1 August 1973

EMPLOYEE IELD OFFICE & INVESTIGATOR	DATE INVESTIGATION COMPLETED	NATURE OF ALLEGATION	$ AMOUNT OF LOSS, IF APPLICABLE	DISPOSITION
1) P.J. (F) Spokane Schaller	4-9-75	EMPLOYEE - RECIPIENT. Unreported income	NA	Resigned - no further action.
2) M.M. (F) Seattle Hobson	4-10-75	EMPLOYEE - RECIPIENT. Illegal receipt of Food Stamps.	NA	Allegation unfounded.
3) M.D. (F) Seattle Hobson	4-16-75	Set up false grant for self.	$470	Pled guilty. Grand Larceny - 18 months deferred, Restitution.
4) C.D. (M) Seattle Hobson	5-19-75	Falsified serving "Notice of Debt" on absent parent.	NA	Employee discharged.
45) K.S. (F) Seattle O'Grady	5-28-75	Possible theft ATP	$105	Convicted. Petty Larceny - 1 year deferred sentence, Restitution.
46) D.L. Everett Barrie	5-29-75	Institution custodial office participated in theft of State property.	NA	No criminal liability. Administrative discipline inflicted - 10 days suspension without pay.
47) C.M.E. (F) Seattle Engelhart	6-12-75	EMPLOYEE - RECIPIENT. Unreported second job.	$577	Convicted in Superior Court. Petty Larceny - probation and restitution.
48) H.J. (F) Seattle Hines	6-26-75	Fictitious Food Stamp Applications (30)	$6,000	Non-provable case as to criminal. Job transfer.

EMPLOYEE MISCONDUCT INVESTIGATIONS

Beginning 1 August 1973

EMPLOYEE FIELD OFFICE & INVESTIGATOR	DATE INVESTIGATION COMPLETED	NATURE OF ALLEGATION	$ AMOUNT OF LOSS, IF APPLICABLE	DISPOSITION
49) E.D. (F) Everett O'Grady	6-28-75	Theft and forgery ATP	$747	Convicted in Superior Court - deferred sentence, Restitution. Employee discharged.
50) W.T. (M) Vancouver Hines	7-1-75	Theft of food from State School for boys.	$960	Referred to Prosecutor. Case dismissed due to death of principal witnesses. Employee discharged.
51) P.H. (F) Seattle Engelhart	7-7-75	Employee assisting A/R in securing drugs.	NA	10 day job suspension.
52) W.C. (M) Spokane Roberts	7-9-75	Pilferage of State property.	$150	Resigned. Property recovered. Local police took jurisdiction.
53) M.C. (F) Spokane Roberts	7-9-75	Pilferage of State Property	$150	Resigned. Property recovered. Local police took jurisdiction.
54) R.P. (M) Seattle O'Grady	7-17-75	EMPLOYEE - RECIPIENT. Failure to report income	$222.60	Unfounded.
55) J.C. (F) Vancouver Ronan	7-25-75	CW living with A/R - Collusion, falsifying eligibility forms.	NA	Employee discharged.
56) L.H. (M) Seattle Engelhart	8-29-75	Redirect of A/R checks for personal gain.	$134	Pled guilty. Sentenced by King County Superior Court to maximum of 5 years, served 4 months in county jail

EMPLOYEE MISCONDUCT INVESTIGATIONS

Beginning 1 August 1973

EMPLOYEE ELD CFFICE & NVESTIGATOR	DATE INVESTIGATION COMPLETED	NATURE OF ALLEGATION	$ AMOUNT OF LOSS, IF APPLICABLE	DISPOSITION
7) D.M. (F) Yakima Gauthier	9-25-75	EMPLOYEE - RECIPIENT. Failure to disclose income (child support) and illegal receipt of Food Stamps.	$732	Pled guilty to Grand Larceny in Superior Court - 3 years probation.
58) C.J.B. (F Seattle Gibson	9-30-75	EMPLOYEE - RECIPIENT. Receiving child care and not paying to provider.	$570	Convicted of Forgery (reduced from Grand Larceny) - 3 years deferred, restitution.
59) T.K. (F) Seattle Hobson	10-21-75	Mishandling of Food Stamp sales.	NA	Returned for administrative action.
60) W.S.P. State Office Trefry	11-12-75	Custody staff abuse of prisoners. One prisoner burned to death and two assaulted	NA	Unfounded. Not fault of custody staff.
61) D.C. (M) Tacoma Buck	11-17-75	Misappropriation of State institution funds.	$400	Restitution ordered by administrative action. No criminal prosecution.
62) D.P. (M) Olympia Hubert	11-25-75	Aiding and abetting fraudulent activity by A/R.	NA	Unprovable.
63) J.C. Seattle Hobson	12-22-75	Collusion - aided A/R to defruad by false application.	$221	Returned from Prosecutor - won't ask for extradition.
64) D.B. (M) Spokane Gregoire	1-6-76	Falsified eligibility forms while A/R (Prior to employment).	$378	Prosecution refused (amount too low). Referred to L.O.A. for administrative action.

EMPLOYEE MISCONDUCT INVESTIGATIONS

Beginning 1 August 1973

EMPLOYEE FIELD OFFICE & INVESTIGATOR	DATE INVESTIGATION COMPLETED	NATURE OF ALLEGATION	$ AMOUNT OF LOSS, IF APPLICABLE	DISPOSITION
65) V.H. (P) Seattle Gibson	1-21-76	Using false name to obtain food stamps	$1,435.00	Convicted - Grand Larceny, Restitution ordered, 10 days in jail, 3 years deferred.
66) D.S. (F) Spokane Schaller	1-21-76	Failed to report income as F.S. recipient		Employee resigned. Investigation to proceed as recipient fraud matter.
67) L.R. (P) Seattle Gurney	1-21-76	Attempted extortion	$450.00	Sentenced to 3 years, 30 days in county jail, 100 hours Community Service for Bribery.
68) J.J. (M) Yakima Neilson	1-26-76	Collusion - aiding and abetting welfare recipient.		No criminal action may be brought due to running of Statute of Limitations
69) E.S. (P) Seattle Barrie	2-4-76	A/P in home while receiving assistance		Allegation not substantiated
70) M.S. (P) Olympia Hines	3-17-76	Forged warrant of recipient	$260	Referred to Prosecutor. Convicted, $100 fine, make restitution $260.
71) J.C. Olympia Tucker	3-31-76	Release of adoption information		Unable to prove allegation
72) G.W. (P) Seattle Templeton	4-20-76	Involved with ring - passing stolen checks		Unable to substantiate

EMPLOYEE MISCONDUCT INVESTIGATIONS

Beginning 1 August 1973

EMPLOYEE, FIELD OFFICE INVESTIGATOR	DATE INVESTIGATION COMPLETED	NATURE OF ALLEGATION	$ AMOUNT OF LOSS, IF APPLICABLE	DISPOSITION
73) F.A. (M) Neilson Seattle	5-25-76	Indecent exposure		Employee resigned
74) M.M. (F) Pt. Townsend Ronan	5-25-76	CETA. EMPLOYEE - RECIPIENT. Unreported income.	$2,669.81	Referred to Prosecutor
75) O.W. (F) Seattle Engelhart	5-27-76	Misuse of telephone	$136.59	Reimbursed
76) A.W. (F) Hobson Seattle	5-28-76	Collusion - aiding and abetting welfare recipient	$225.00	Arrest warrant issued 6-18-76

EXHIBIT R

STATE OF WASHINGTON DEPARTMENT OF SOCIAL AND HEALTH SERVICES

APPLICATION FOR ASSISTANCE

INSTRUCTIONS: THE FOLLOWING IS A STATEMENT OF FACTS ABOUT YOUR SITUATION. PLEASE READ EACH QUESTION CAREFULLY AND ANSWER EACH ONE. THE INFORMATION YOU GIVE WILL BE USED TO DETERMINE YOUR ELIGIBILITY, THE AMOUNT OF ASSISTANCE AND NATURE OF SERVICES THAT YOU MAY RECEIVE. UPON COMPLETION OF THIS FORM, YOU WILL BE REQUIRED TO ATTEST TO THE FACTS SUBJECT TO PENALTIES AS PROVIDED IN RCW 74 08 055. PLEASE USE A BALL POINT PEN TO COMPLETE THIS FORM

PLEASE PRINT YOUR FULL NAME AND ADDRESS BELOW — DATE AND SIGN LAST PAGE

LAST NAME	FIRST NAME	MIDDLE NAME	OFFICE USE	BASIC NUMBER
MAILING ADDRESS	STREET ADDRESS (If Different)	APT. NO.		LOCAL OFFICE
CITY OR TOWN	ZIP CODE	TELEPHONE NOS. WHERE YOU CAN BE REACHED 1. 2.		DATE OF REQUEST

I AM APPLYING FOR ASSISTANCE BECAUSE . . .

I AM APPLYING FOR THE FOLLOWING PERSONS WHO ARE LIVING WITH ME. INCLUDE YOURSELF IF IN NEED OF ASSISTANCE.	BIRTH DATE			SEX	RELATIONSHIP TO ME	U.S. CITIZEN Yes/No	IN SCHOOL NAME SCHOOL	SOC. SEC. NUMBER
LAST NAME FIRST NAME MIDDLE NAME	Month	Day	Year					
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

NAME OF OTHER PERSONS LIVING WITH ME WHETHER RELATED OR NOT:	RELATIONSHIP TO ME	NOW RECEIVING WELFARE		MONTHLY INCOME
LAST NAME FIRST NAME MIDDLE NAME		Yes	No	
1.				
2.				
3.				
4.				

I AM NOW: SINGLE ○ MARRIED ○ DIVORCED ○ WIDOWED ○ SEPARATED ○

IF SEPARATED, SHOW THE DATE THAT THE SEPARATION OCCURRED ....

I AM, OR A MEMBER OF MY HOUSEHOLD IS EXPECTING A BABY YES ○ NO ○

IF YES, EXPECTANT MOTHER'S NAME IS .... EXPECTED DATE OF BIRTH ....

LOTHROP business forms Seattle 284 8/00

IF YOU HAVE ANSWERED ALL QUESTIONS, TURN TO PAGE 2

1. I AM NOW RECEIVING OR HAVE IN THE PAST RECEIVED FINANCIAL OR MEDICAL ASSISTANCE FROM A PUBLIC ASSISTANCE OFFICE OF THIS STATE (INCLUDING THIS OFFICE) OR SOME OTHER STATE. YES ○ NO ○

IF YES, WHICH OFFICE OR OTHER STATE? .... DATE LAST RECEIVED................

WHAT WAS YOUR NAME AT THAT TIME? ....

2. I have, or a member of my household has received some type of income this month. YES ○ NO ○
IF YES, WHEN? .... WHAT AMOUNT? ....
SOURCE OF INCOME ....

3. I AM, OR A MEMBER OF MY HOUSEHOLD IS WORKING AT THIS TIME .... YES ○ NO ○
IF YES, COMPLETE BELOW

		NAME OF EMPLOYED PERSON	NAME OF EMPLOYED PERSON	NAME OF EMPLOYED PERSON
a. EMPLOYER'S NAME				
b. EMPLOYER'S ADDRESS				
c. KIND OF WORK				
d. Total Number of Hours and Days Worked Per Month		TOTAL HRS. TOTAL DAYS	TOTAL HRS. TOTAL DAYS	TOTAL HRS. TOTAL DAYS
e. How Often Are You Paid? (every day, week, month, etc.)		$	$	$
f. Total Pay Per Pay Period (not take home pay)		$	$	$
g. AMOUNT DEDUCTED FOR (per pay period)	1. Income Tax	$	$	$
	2. Social Security	$	$	$
	3. Union Dues	$	$	$
	4. Other	$	$	$
h. Total Take Home Pay (per pay period)		$	$	$
i. DAILY TRANSP. COST	1. Bus Fare	$ PER DAY	$ PER DAY	$ PER DAY
	2. Number of Miles to and from Work	BOTH WAYS PER DAY	BOTH WAYS PER DAY	BOTH WAYS PER DAY
	3. Car Pool Cost	$ PER DAY	$ PER DAY	$ PER DAY

4. I HAVE, OR A MEMBER OF MY HOUSEHOLD HAS LOST A JOB OR QUIT WORKING WITHIN THE LAST SIXTY DAYS .... YES ○ NO ○
IF YES, COMPLETE BELOW

NAME.......................... HAS WITHIN THE LAST 60 DAYS: PLEASE CHECK (✓) EACH ITEM

	YES	NO
BEEN LAID OFF	○	○
GONE ON STRIKE	○	○
BEEN FIRED	○	○
QUIT WORK	○	○
REFUSED WORK	○	○
REFUSED A TRAINING ASSIGNMENT	○	○

COMPLETE FOR ANY "YES" ANSWER

a. WHEN.............................. b. WHY..............
....
....
c. AMOUNT OF PAY DUE $..
d. DATE EXPECTED TO RECEIVE PAY ....

IF YOU HAVE ANSWERED ALL QUESTIONS, TURN TO PAGE 3

5. I CONSIDER MYSELF ABLE TO WORK AT THIS TIME .... YES ○ NO ○
I CONSIDER MY WIFE OR HUSBAND ABLE TO WORK AT THIS TIME .... YES ○ NO ○
IF NO, EXPLAIN WHY FOR EACH ....
I last worked (date) .... My wife or husband last worked (date) ....

6. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME RECEIVE MONEY FROM THE FOLLOWING SOURCES, (Check each item "Yes or No") .

SOURCE OF MONEY	YES (✓)	NO (✓)	APPLIED FOR (✓)	FOR WHOM	AMOUNT RECEIVED	CLAIM NO. (if any)	HOW OFTEN RECEIVED
a. Child Support Payments					$		
b. Social Security Benefits (1)					$		
c. Social Security Benefits (2)					$		
d. Railroad Retirement					$		
e. Supplemental Security Income (SSI)					$		
f. Veterans' Benefits					$		
g. Unemployment Compensation					$		
h. Military Allotment					$		
i. Indian Payments (Per Capita)					$		
j. Industrial Accident Payments (Labor & Industries)					$		
k. Payment from Boarders					$		
l. Money from Relatives					$		
m. Money from Rental Property					$		
n. Caring for Children					$		
o. Other Money or Benefits (not wages)					$		

7. I AM, OR A MEMBER OF MY HOUSEHOLD IS AN ENROLLED INDIAN .... YES ○ NO ○
IF YES, NAME OF TRIBE IS .... NAME OF MEMBER IS ....
DOES YOUR TRIBE HAVE BURIAL BENEFITS? .... ○ ○

8. I AM, OR A MEMBER OF MY FAMILY IS, OR WAS, A VETERAN OF THE ARMED SERVICES. YES ○ NO ○
IF YES, NAME OF VETERAN IS/OR WAS ....
V.A. CLAIM NO. IS .... SERVICE NO. IS ....
TIME IN SERVICE WAS FROM (date) .... TO (date) ....

9. I AM NOW MAKING CHILD SUPPORT PAYMENTS .... YES ○ NO ○
IF YES, TOTAL MONTHLY PAYMENTS ARE $ .... COURT ORDER NO. IS ....

10. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME HAS SOME KIND(S) OF INSURANCE, (LIFE, BURIAL, ETC. DO NOT INCLUDE MEDICAL) .... YES ○ NO ○
IF YES, COMPLETE BELOW

KIND OF INSURANCE	NAME OF COMPANY	POLICY NO	FACE VALUE	DATE ISSUED	CASH VALUE	NAME OF INSURED	NAME & ADDRESS OF BENEFICIARY
a.							
b.							
c.							

11. I, MY WIFE OR HUSBAND, OR A DEPENDENT LIVING WITH ME, HAS SOME KINDS OF MEDICAL INSURANCE (INCLUDE VETERANS, MEDICAL COVERAGE THROUGH AUTO INSURANCE). IF YES, COMPLETE BELOW YES ○ NO ○

NAME OF INSURANCE CO. UNION OR OTHER	NAME OF PERSON COVERED	MONTHLY PAYMENT	DOES THIS PAY FOR						OTHER COVERAGE (OXYGEN, AMBULANCE ETC.)
			HOSPITAL		DOCTOR		DRUGS		
			YES	NO	YES	NO	YES	NO	
a.		$							
b.		$							
c.		$							

12. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME OWNS OR HAVE A SHARE IN ONE OR MORE OF THE FOLLOWING ITEMS: YES ○ NO ○
IF YES, COMPLETE BELOW

ITEM	AMOUNT OR VALUE	WHO IT BELONGS TO	WHERE IT IS LOCATED (Name of Bank If Applicable)
a. MONEY ON HAND	$		
b. Money Held for You by Others	$		
c. CHECKING ACCOUNT	$		
d. SAVINGS ACCOUNT	$		

13. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME OWNS OR HAVE A SHARE IN ONE OR MORE OF THE FOLLOWING ITEMS: STOCKS, BONDS, SALES CONTRACTS, RETIREMENT FUND, TRUST ACCOUNT. YES ○ NO ○ IF YES, COMPLETE SUPPLEMENT

14. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME OWNS OR IS BUYING ONE OR MORE OF THE FOLLOWING VEHICLES. YES ○ NO ○
IF YES, COMPLETE BELOW

VEHICLE	MAKE AND YEAR	MODEL	APPROX. VALUE	AMOUNT OWED
a. AUTOMOBILE			$	$
b. AUTOMOBILE - 2			$	$
c. TRUCK			$	$

15. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME OWNS OR IS BUYING ONE OR MORE OF THE FOLLOWING ITEMS: BOAT, SNOWMOBILE, CAMPER, TRAILER, MOTORCYCLE, OR SIMILAR ITEMS .... YES ○ NO ○ IF YES, COMPLETE SUPPLEMENT

IF YOU HAVE ANSWERED ALL QUESTIONS TURN TO PAGE 5

16. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME OWNS OR IS BUYING ONE OR MORE OF THE FOLLOWING ITEMS: LIVESTOCK, POULTRY, CROPS, TIMBER, BUSINESS EQUIPMENT, MINING OPERATION, TOOLS, FARM MACHINERY, OR SIMILAR ITEMS . . . . . . YES ○ NO ○ IF YES, COMPLETE SUPPLEMENT

17. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME HAS SOLD, TRADED, OR GIVEN TO SOMEONE PERSONAL PROPERTY (Such as cars, cash investment money) WITHIN THE LAST TWO YEARS . . . . YES ○ NO ○ IF YES, COMPLETE SUPPLEMENT

18. I, OR A MEMBER OF MY HOUSEHOLD RECEIVES HOUSING FREE ON A REGULAR BASIS YES ○ NO ○

19. I RENT AND MY MONTHLY PAYMENT IS $. . . . .
I LIVE IN ONE OF THE FOLLOWING: (Please check which one).
○ BOARDING HOME ○ NURSING HOME ○ HOSPITAL ○ HOUSE ○ ROOM OR APARTMENT

I SHARE MY LIVING ARRANGEMENTS WITH ANOTHER PERSON(S) WHO IS RECEIVING AN ASSISTANCE GRANT YES ○ NO ○
I/WE PAY SEPARATLEY FOR ONE OF THE FOLLOWING UTILITIES: ELECTRICITY, GAS, HEAT, WATER YES ○ NO ○

20. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME OWN OR AM BUYING THE HOUSE IN WHICH I LIVE . . . . OWN ○ BUYING ○ (CHECK ONE) YES ○ NO ○
IF YES, COMPLETE BELOW

a. DESCRIPTION, INCLUDING NUMBER AND SIZE OF LOT(S) OR ACREAGE AND LEGAL DESCRIPTION.
. . . .
b. MONTHLY PAYMENT $ . . . . c. BALANCE DUE $ . . . .
d. ARE YOUR YEARLY PROPERTY TAXES INCLUDED IN YOUR MONTHLY PAYMENTS? YES ○ NO ○
e. IF YOUR TAXES ARE NOT INCLUDED IN YOUR MONTHLY PAYMENTS, SHOW THE AMOUNT OF YEARLY TAXES SHOWN ON YOUR TAX STATEMENT. $ . . . .

f. ARE YOU PAYING FOR ANY ASSESSMENTS TO YOUR PROPERTY? (Such as for street improvements, sewer, sidewalk, irrigation, etc.) . . . . YES ○ NO ○
g. IF YES, WHAT TYPE OF ASSESSMENT(S) . . . . ANNUAL PAYMENT IS $. . . . .

21. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME OWNS OR IS BUYING THE MOBILE HOME IN WHICH I LIVE. . . OWN ○ BUYING ○ (CHECK ONE) YES ○ NO ○ IF YES, COMPLETE SUPPLEMENT

22. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME OWNS OR IS BUYING SOME PROPERTY IN WHICH I AM NOT LIVING . . . . YES ○ NO ○ IF YES, COMPLETE SUPPLEMENT

23. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME OWNS OR HAS A SHARE IN SOME REAL PROPERTY NOT ALREADY DESCRIBED (Such as Life Estate or Indian Land) YES ○ NO ○ IF YES, COMPLETE SUPPLEMENT

24. I, MY WIFE OR HUSBAND OR A DEPENDENT LIVING WITH ME HAS SOLD, TRADED OR GIVEN TO SOMEONE REAL PROPERTY (LAND OR BUILDINGS) WITHIN THE LAST TWO YEARS YES ○ NO ○ IF YES, COMPLETE SUPPLEMENT

	YES	NO	
25. I AM NOW MAKING "MEDICARE" MONTHLY PAYMENTS	○	○	
MY WIFE IS NOW MAKING "MEDICARE" MONTHLY PAYMENTS	○	○	
I HAVE, OR MY WIFE OR HUSBAND HAS APPLIED FOR "MEDICARE"	○	○	
IF YES, NAME OF PERSON APPLIED .... DATE APPLIED .... CLAIM NO.			
26. I HAVE, OR A MEMBER OF MY HOUSEHOLD HAS A PREPAID FUNERAL PLAN (NOT LIFE INSURANCE) OR MONEY LEFT WITH OTHERS TO COVER FUNERAL EXPENSES	○	○	IF YES, COMPLETE SUPPLEMENT
27. I OR A MEMBER OF MY HOUSEHOLD OWNS OR IS BUYING A BURIAL PLOT OR PLOTS	○	○	IF YES, COMPLETE SUPPLEMENT
28. I WANT TO BUY FOOD STAMPS OR RECEIVE COMMODITIES	○	○	
I WANT THE COST OF FOOD STAMPS DEDUCTED FROM ASSISTANCE PAYMENT OR I WANT FOOD STAMP PURCHASE CARDS ○ MONTHLY ○ SEMI-MONTHLY (check one)	○	○	
29. I HAVE BEEN LIVING IN WASHINGTON SINCE (Date)..................................			
I INTEND TO KEEP MY RESIDENCE IN WASHINGTON	○	○	

I declare under penalty of perjury that the information given by me in this declaration is true, correct and complete to the best of my knowledge and realize that willful falsification of this information by me may subject me to penalties as provided in Washington State Law, RCW 74.08.055.

I understand that I am required to report immediately to the local office any changes in my income, resources, or living arrangements.

I realize that my statements may be subject to complete verification by the Department of Social & Health Services. If I do not provide such verification, I hereby authorize the Department to contact other persons or agencies to obtain the necessary verification.

I understand that the information reported in this declaration will be used to determine my eligibility for public assistance and the amount of benefits I will receive.

BOTH HUSBAND AND WIFE MUST SIGN IF LIVING TOGETHER.

SIGNATURE OF APPLICANTS .... (Date)..............

.... (Date)..............

SIGNATURE OF PERSON HELPING APPLICANT(S) .... (Date)..............

IF APPLICANT SIGNS BY "X" ABOVE, HIS NAME SHOULD BE WRITTEN HERE BY A FRIEND OR RELATIVE .... (Date)..............

IF SIGNED BY "X" ABOVE, WITNESSES MUST SIGN HERE 1 .... (Date)..............

2 .... (Date)..............

BE SURE YOU HAVE ANSWERED ALL QUESTIONS AND SIGNED YOUR NAME

DSHS 14-01 (X) (REV. 4-76)
(MP 15-1)

FOR OFFICE USE ONLY

Discussed with Client

	Yes	No
Right to Fair Hearing		
Civil Rights		
Confidentiality		
Changes in Circumstances to be rep't in writing		
Penalties of Perjury		
Food Stamp Program		
Med. Program		
Social Services		

The above rights and responsibilities have been explained and the applicant(s) stated they understood

Date

Financial Service Technician

FOR OFFICE USE ONLY

ROUTE TO BANK ○ BANK WAITING LIST ○ ONGOING ○ ENTRY ○

MARRIAGES OF MAN		MARRIAGES OF WOMAN	
TO	DATE	TO	DATE
PLACE	TERMINATED BY	PLACE	TERMINATED BY
PLACE	DATE	PLACE	DATE
TO	DATE	TO	DATE
PLACE	TERMINATED BY	PLACE	TERMINATED BY
PLACE	DATE	PLACE	DATE

DIRECTIONS FOR FINDING HOME:

ADDITIONAL PERSONAL INFORMATION

DATE	TIME COMPLETED AM PM	[illegible]

EXHIBIT S

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

MEDICAL SUPPLEMENT

This form is for additional information about your particular situation. Please answer each question carefully. The information will be used in determining your eligibility.

NAME ______________________

Office Use Only
Basic No.

1. I, my wife or husband, or a dependent living with me, am in need of medical care. Yes ○ No ○

If yes, complete below:

NAMES OF PERSONS IN NEED	MEDICAL PROBLEM
a.	
b.	
c.	
d.	

2. I, my wife or husband, or a dependent living with me, am NOW under a doctor's care. Yes ○ No ○

If yes, complete below:

NAMES OF PERSONS UNDER CARE	DOCTORS' NAME	DATE LAST SEEN
a.		
b.		
c.		
d.		

3. I, my wife or husband, or a dependent living with me, am NOW taking medicine that is regularly prescribed by my doctor. Yes ○ No ○

If yes, complete below:

NAMES OF PERSONS TAKING MEDICINE	PROBLEM MEDICINE IS FOR
a.	
b.	
c.	
d.	

4. I NOW owe for or am paying on the following services received in the LAST three (3) months: Yes ○ No ○

If yes, check appropriate boxes: ☐ Hospital, ☐ Medical, ☐ Other Health Care.

If yes, I owe $__________ and or am paying $__________ per month.

After you have answered all questions - complete back of form if appropriate.

5. I am NOW paying on a bill, contract, or loan for home repairs. Yes ○ No ○

If yes, I pay $__________ per month and I still owe $__________.

6. During each of the LAST six (6) months, I have earned, after deductions:

1. Month __________ Amount $__________ 4. Month __________ Amount $__________

2. Month __________ Amount $__________ 5. Month __________ Amount $__________

3. Month __________ Amount $__________ 6. Month __________ Amount $__________

7. During each of the NEXT six (6) months, I expect to earn, after deductions:

1. Month __________ Amount $__________ 4. Month __________ Amount $__________

2. Month __________ Amount $__________ 5. Month __________ Amount $__________

3. Month __________ Amount $__________ 6. Month __________ Amount $__________

I declare under penalties of perjury that the information given by me on this form is true, correct and complete to the best of my knowledge.

I realize that my statements may be subject to complete verification by the Department of Social and Health Services.

Signature of Applicant(s) ______________________________ Date __________

______________________________ Date __________

EXHIBIT T

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

STATEMENT OF EMPLOYMENT AND HEALTH

Office Use Only	Case # ______________
	Worker ______________

Please answer each question carefully. This information will be confidential and will be used in determining your eligibility for an appropriate public assistance program.

Print Your Name ______________ (Last) (First) (Middle) Your birthdate ______________

Your sex ______________

Your Address ______________

____

A. EDUCATION AND TRAINING

1. What was the highest grade you completed in school? ______________

2. Have you ever received special training to learn how to do a job? Yes ____ No ____

If *YES* where was training? ______________

What was the training? ______________

When ? ______________ How long ? ______________

How long did you work as a result of the training ? ______________

B WORK HISTORY

3. What do you consider your usual occupation? ______________

4. What other kinds of jobs have you had ? ______________

____

5. When did you work last ? ______________ How long did you work? ______________

What kind of work ? ______________

6. How many jobs have you had in the last 10 years ? ______________

7. What job have you worked the longest ? ______________

When? ______________

DSHS 14-50
14PA50F REV 4/71 (2)

8. Have you ever *lost* or *left* a job because of your health? Yes ☐ No ☐

IF YES, what was the job? ______________________________

When? ______________________________

What was the health problem and how did it affect your work? ______________________________

____

9. Have you ever been *turned down* for a job because of your health? Yes ☐ No ☐

What was the job? ______________________________

When? ______________________________

What was the health problem? ______________________________

10. Do you have any health problem which prevents you from working now? Yes ☐ No ☐

IF YES, what is the health problem and how does it prevent you from working? ______________________________

____

11. are there any other reasons you feel you cannot work now? Yes ☐ No ☐

IF YES, please explain ______________________________

____

____

12. Do you keep house for anyone other than yourself? Yes ☐ No ☐

IF NO, do not answer the next questions — Go to Section C.

IF YES, do you need help with:

	Yes	No		Yes	No
Shopping for food and supplies			Washing and ironing		
Preparing meals			Scrubbing floors		
Washing dishes			Washing windows		
Cleaning house			Moving furniture		
Making beds			Child care		

C. HEALTH AND MEDICAL INFORMATION

13. What health problems do you have at this time? ______________________________

____

____

14. Are you under care of a doctor or clinic now? Yes ☐ No ☐

IF YES,

Doctor's or clinic's name and address ____________________

What kind of problem? ____________________

What does he tell you to do or not to do about your health? ____________________

How long have you had this problem? ____________________

IF NO,

When was the last time you were seen by a doctor or clinic? ____________________

Doctor or clinic's name and address ____________________

15. Do you take medicine that is prescribed by a doctor? Yes ☐ No ☐

IF YES, for what condition(s) ____________________

D. BENEFITS

16. Have you applied or are you receiving disability benefits from:

Social Security Administration Yes ☐ No ☐

Veteran's Administration Yes ☐ No ☐

State Department of Labor and Industries Yes ☐ No ☐

I declare under penalties of perjury that the information given by me on this Statement of Employment and Health is true, correct and complete to the best of my knowledge.

I realize that my statements may be subject to complete verification by the Department of Social and Health Services.

SIGNATURE OF APPLICANT ____________________ DATE ____________

EXHIBIT U

STATE OF WASHINGTON • DEPARTMENT OF SOCIAL AND HEALTH SERVICES

PERSONAL PROPERTY

APPLICATION SUPPLEMENT

NAME	OFFICE USE ONLY BASIC NUMBER

⑬ IF YOU, YOUR WIFE OR HUSBAND OR A DEPENDENT LIVING WITH YOU OWN OR HAVE A SHARE IN ANY OF THE ITEMS LISTED BELOW, PLEASE COMPLETE THE FOLLOWING:

ITEM	AMOUNT OR VALUE	WHO IT BELONGS TO	WHERE IT IS LOCATED (Name of Bank If Applicable)
a. STOCKS AND BONDS	$		
b. NOTES	$		
c. SALES CONTRACTS	$		
d. RETIREMENT FUND	$		
e. TRUST ACCOUNT	$		
f. OTHER (specify)	$		

⑮ IF YOU, YOUR WIFE OR HUSBAND OR A DEPENDENT LIVING WITH YOU OWN OR ARE BUYING ANY VEHICLES FOR TRANSPORTATION OR SPORT, PLEASE COMPLETE THE FOLLOWING:

VEHICLE	MAKE AND YEAR	MODEL	APPROX. VALUE	AMOUNT DUE
a. BOAT or SNOWMOBILE			$	$
b. TRAILER or CAMPER			$	$
c. MOTORCYCLE			$	$
d. OTHER (specify)			$	$

⑯ IF YOU, YOUR WIFE OR HUSBAND OR A DEPENDENT LIVING WITH YOU OWN OR ARE BUYING ANY OF THE FOLLOWING ITEMS, PLEASE COMPLETE THE FOLLOWING:

ITEM	DESCRIBE	APPROXIMATE VALUE	AMOUNT OWED	HOW DO YOU PLAN TO USE THIS?
a. LIVESTOCK		$	$	
b. POULTRY		$	$	
c. CROPS		$	$	
d. TIMBER		$	$	
e. MINING OPERATION		$	$	
f. TOOLS		$	$	
g. FARM MACHINERY		$	$	
h. BUSINESS EQUIPMENT OR OTHER (specify)		$	$	
i.		$	$	

DSHS 14-80(X) RFIS-6 Rev 7-72

STATE PRINTING PLANT OLYMPIA, WASHINGTON

⑰ IF YOU, YOUR WIFE OR HUSBAND, OR A DEPENDENT LIVING WITH YOU HAVE SOLD, TRADED OR GIVEN TO SOMEONE ANY PERSONAL PROPERTY WITHIN THE LAST TWO YEARS, PLEASE COMPLETE THE FOLLOWING:

TYPE OF PROPERTY TRANSFERRED	WHO DID YOU SELL, TRADE OR GIVE IT TO?	DATE TRANSFERRED	AMOUNT RECEIVED
a.			$
b.			$
c.			$

㉑ IF YOU, YOUR WIFE OR HUSBAND OR A DEPENDENT LIVING WITH YOU OWN OR ARE BUYING THE MOBILE HOME IN WHICH YOU LIVE, PLEASE COMPLETE THE FOLLOWING:

a. MONTHLY PAYMENT IS $ .... b. BALANCE DUE ON MORTGAGE IS $ ....

c. AMOUNT PAID FOR TRAILER SPACE EACH MONTH IS $ ....

d. AMOUNT FOR MOBILE HOME LICENSE FEE OR PROPERTY TAX EACH YEAR IS $ ....

e. IF YOU PAY PROPERTY TAX, ARE YOU CLAIMING THE $50 EXEMPTION? (If man 65 or over or woman 62 or over) .... YES ○ NO ○

㉒ IF YOU, YOUR WIFE OR HUSBAND OR A DEPENDENT LIVING WITH YOU OWN OR ARE BUYING PROPERTY IN WHICH YOU ARE NOT LIVING, PLEASE COMPLETE THE FOLLOWING:

a. ADDRESS OR LEGAL DESCRIPTION ....

b. DESCRIPTION, INCLUDING NUMBER AND SIZE OF LOT(S) OR ACREAGE ....
(For example: 4 room house on 1 acre—no other buildings)

c. HOW ARE YOU USING THIS PROPERTY? ....

d. APPROXIMATE VALUE $ .... e. MONTHLY PAYMENTS $ .... f. BALANCE DUE $ ....

g. IF **RENTED,** HOW MUCH DO YOU RECEIVE EACH MONTH? $ ....

h. IF **NOT RENTED,** HAVE YOU MADE ANY EFFORTS TO RENT OR SELL THIS PROPERTY? ....

DESCRIBE YOUR EFFORTS ....

㉓ IF YOU, YOUR WIFE OR HUSBAND, OR A DEPENDENT LIVING WITH YOU OWN OR HAVE A SHARE IN SOME REAL PROPERTY THAT HAS NOT BEEN DESCRIBED (LIFE ESTATE, INDIAN LAND, (ETC.) PLEASE COMPLETE THE FOLLOWING:

a. ADDRESS OR LEGAL DESCRIPTION ....

b. DESCRIPTION, INCLUDING NUMBER AND SIZE OF LOT(S) OR ACREAGE ....
(For example 10 acres of Indian land)

c. HOW ARE YOU USING THIS PROPERTY? ....

d. ARE YOU CLAIMING A PROPERTY TAX EXEMPTION? (HOW MUCH $ ....) YES ○ NO ○

e. NAME AND ADDRESS OF TITLE HOLDER ....

㉔ IF YOU, YOUR WIFE OR HUSBAND, OR A DEPENDENT LIVING WITH YOU HAVE SOLD, TRADED OR GIVEN TO SOME ONE SOME REAL PROPERTY IN THE LAST TWO YEARS, PLEASE COMPLETE THE FOLLOWING:

a. ADDRESS OR LEGAL DESCRIPTION

b. DESCRIPTION, INCLUDING NUMBER AND SIZE OF LOT(S) OR ACREAGE
(For example: 4 room house on 1 acre—no other buildings)

c. DATE TRANSFERRED .... d. VALUE AT TIME OF TRANSFER $

e. AMOUNT OWED AT TIME OF TRANSFER $ .... f. SALE PRICE $

g. BALANCE NOW DUE TO US $ .... h. MONTHLY PAYMENT TO US $

i. NAME AND ADDRESS OF PERSON TO WHOM TRANSFERRED

㉖ IF YOU OR A MEMBER OF YOUR HOUSEHOLD HAVE A PREPAID FUNERAL PLAN (NOT LIFE INSURANCE) OR MONEY LEFT WITH OTHERS TO COVER FUNERAL EXPENSES PLEASE COMPLETE THE FOLLOWING:

a. WHO IS IT WITH? (Name and Address)

b. AMOUNT $ c. THIS MONEY IS AVAILABLE TO ME ○ Yes ○ No

d. IF NOT WHY NOT

㉗ IF YOU OR A MEMBER OF YOUR HOUSEHOLD OWN OR ARE BUYING A BURIAL PLOT OR PLOTS PLEASE COMPLETE THE FOLLOWING:

a. NUMBER OF PLOTS .... b. DATE PURCHASED

c. NAME AND LOCATION OF CEMETERY

I DECLARE UNDER PENALTIES OF PERJURY THAT THE INFORMATION GIVEN BY ME IN THIS APPLICATION FORM IS TRUE, CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND REALIZE THAT WILLFUL FALSIFICATION OF THIS INFORMATION BY ME MAY SUBJECT ME TO PENALTIES AS PROVIDED IN RCW 74.08.055.

I UNDERSTAND THAT IT IS MY DUTY TO REPORT IMMEDIATELY TO THE LOCAL OFFICE ANY CHANGES IN MY INCOME, RESOURCES, OR LIVING ARRANGEMENTS.

I REALIZE THAT MY STATEMENTS MAY BE SUBJECT TO COMPLETE VERIFICATION BY THE DEPARTMENT OF SOCIAL AND HEALTH SERVICES.

BOTH HUSBAND AND WIFE MUST SIGN IF LIVING TOGETHER.

SIGNATURE OF APPLICANTS .... (Date) ....

.... (Date) ....

SIGNATURE OF PERSON HELPING APPLICANT(S) .... (Date) ....

IF APPLICANT SIGNS BY "X" ABOVE, HIS NAME SHOULD BE WRITTEN HERE BY A FRIEND OR RELATIVE. .... (Date) ....

IF SIGNED BY "X" ABOVE, WITNESSES MUST SIGN HERE 1. .... (Date) ....

2. .... (Date) ....

⑰ IF YOU, YOUR WIFE OR HUSBAND, OR A DEPENDENT LIVING WITH YOU HAVE SOLD, TRADED OR GIVEN TO SOMEONE ANY PERSONAL PROPERTY WITHIN THE LAST TWO YEARS, PLEASE COMPLETE THE FOLLOWING:

TYPE OF PROPERTY TRANSFERRED	WHO DID YOU SELL, TRADE OR GIVE IT TO?	DATE TRANSFERRED	AMOUNT RECEIVED
a.			$
b.			$
c.			$

㉑ IF YOU, YOUR WIFE OR HUSBAND OR A DEPENDENT LIVING WITH YOU OWN OR ARE BUYING THE MOBILE HOME IN WHICH YOU LIVE, PLEASE COMPLETE THE FOLLOWING:

a. MONTHLY PAYMENT IS $........ b. BALANCE DUE ON MORTGAGE IS $........

c. AMOUNT PAID FOR TRAILER SPACE EACH MONTH IS $........

d. AMOUNT FOR MOBILE HOME LICENSE FEE OR PROPERTY TAX EACH YEAR IS $........

e. IF YOU PAY PROPERTY TAX, ARE YOU CLAIMING THE $50 EXEMPTION? (If man 65 or over or woman 62 or over)........ YES ○ NO ○

㉒ IF YOU, YOUR WIFE OR HUSBAND OR A DEPENDENT LIVING WITH YOU OWN OR ARE BUYING PROPERTY IN WHICH YOU ARE NOT LIVING, PLEASE COMPLETE THE FOLLOWING:

a. ADDRESS OR LEGAL DESCRIPTION ....

....

b. DESCRIPTION, INCLUDING NUMBER AND SIZE OF LOT(S) OR ACREAGE ....
(For example: 4 room house on 1 acre—no other buildings)

....

c. HOW ARE YOU USING THIS PROPERTY? ....

d. APPROXIMATE VALUE $........ e. MONTHLY PAYMENTS $........ f. BALANCE DUE $........

g. IF **RENTED,** HOW MUCH DO YOU RECEIVE EACH MONTH? $........

h. IF **NOT RENTED,** HAVE YOU MADE ANY EFFORTS TO RENT OR SELL THIS PROPERTY? ....

DESCRIBE YOUR EFFORTS ....

㉓ IF YOU, YOUR WIFE OR HUSBAND, OR A DEPENDENT LIVING WITH YOU OWN OR HAVE A SHARE IN SOME REAL PROPERTY THAT HAS NOT BEEN DESCRIBED (LIFE ESTATE, INDIAN LAND, (ETC.) PLEASE COMPLETE THE FOLLOWING:

a. ADDRESS OR LEGAL DESCRIPTION ....

b. DESCRIPTION, INCLUDING NUMBER AND SIZE OF LOT(S) OR ACREAGE ....
(For example: 10 acres of Indian land)

....

c. HOW ARE YOU USING THIS PROPERTY? ....

d. ARE YOU CLAIMING A PROPERTY TAX EXEMPTION? (HOW MUCH $........) YES ○ NO ○

e. NAME AND ADDRESS OF TITLE HOLDER ....

....

EXHIBIT V

GAU VERIFICATION REQUIREMENTS

1. PERSONAL IDENTIFICATION

   Valid Driver's License; Social Security Card; Current Student Body Card; Birth Certificate; Marriage License; Military I.D. Card; Draft Registration Card; Baptismal Certificate; Unexpired Credit Cards; Liquor Control I.D. Card or Washington State Identicard.

2. ADDRESS VERIFICATION

   Rental or Lease Agreement; House Payment Booklet; Current Rent Receipt with Landlord's name, address and telephone number; Current Utility Bills or Tax Notice.

3. SOCIAL SECURITY CARDS For All Members of Household Having Social Security Numbers.

4. INFORMATION RELATED TO ANY CHILD SUPPORT BEING PAID OR RECEIVED

   Court Order, etc.

5. VERIFICATION OF INCOME OTHER THAN PUBLIC ASSISTANCE

   Social Security Award Letter; Veteran's Pension Award Letter; Labor & Industries Award Letter; Indian Tribal Benefit Award Letter, etc.

6. COPIES OF ALL INSURANCE POLICIES including Burial Plans.

7. VERIFICATION OF BANK ACCOUNTS

   Savings Books; Check Books or Current Bank Statement.

8. REGISTRATION FOR ALL VEHICLES

   Cars, trucks, boats, cycles, etc.

9. VERIFICATION OF UTILITY EXPENSES

   Telephone, Electricity, Gas or Fuel Oil Bills or Receipts.

10. VERIFICATION OF SHELTER COSTS

    Deeds; Mortgage Agreements; Property Tax Settlements; Rental or Lease Agreements.

11. STOCK CERTIFICATES, BONDS, MUTUAL FUND SHARES, OR TRUST ACCOUNTS, if any.

12. A COPY of Any Sales Contract or A Description of Any Property That You Own, Are Buying or Have Sold or Traded.

13. VERIFICATION OF UNEMPLOYABILITY

    Current Medical Statement from Your Doctor with Diagnosis, Prognosis and Length of Unemployability.

14. ALIEN REGISTRATION CARD (if Applicable)

K-97
Rev. 3-12-75

CMS LIBRARY
3 8095 00014243 6